

Rev. 5-17-39
1 X1951

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 12 1940

Registration District No. 1000

Primary Registration District No. _____

Registrar's No. 11127

1. PLACE OF DEATH: 1

(a) County _____

(b) City or town St Louis

(c) Name of hospital or institution: Homer G Phillips Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 17 days
(Specify whether _____)
Unknown (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County _____

(c) City or town St Louis 25
(If outside city or town limits, write "RURAL")

(d) Street No. 1424 N 9th
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Alice Wright 623

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 27 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business Unknown

12. Name Jim Maringo

13. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Charlotte ?

15. Birthplace Georgia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Florence J Spitt

(b) Address Homer Phillip Hospital

17. (a) _____ (b) Date, thereof 12 15 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. R. R.

(b) Address 3500 Ritz

19. (a) DEC 28 1938 (b) J. P. R. R.
(Date of medical registration) (Physician's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11
year 1939 hour 12:00 minute 25 AM.

21. I hereby certify that I attended the deceased from November 25, 1939, to December, 1939;
that I last saw her alive on December 11, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease 2
Duration 8-10yrs

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature H. J. Lyman (M. D. or other)

Address 2600 N Whittier Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....,
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.