

FILED MAR 12 1940  
791

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 1710

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mos 4 days  
(Specify whether  
In this community Unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis 22  
(If outside city or town limits, write "RURAL")  
(d) Street No. 909 Ohio  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16  
year 1940 hour 7:55 minute A M.

21. I hereby certify that I attended the deceased from  
November 11 1939 to February 16 1940,  
that I last saw her alive on February 16 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Peritoneum, Tuberculosis  
Bronchopneumonia  
Duration  
4 mos  
2-3das

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy: Peritoneum, Tuberculosis  
Bronchopneumonia  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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)  
(c) Means of injury \_\_\_\_\_

23. Signature H. J. Lyman (M. D. or other)  
Address 2601 N Whittier Date signed \_\_\_\_\_

8. (a) PRINT FULL NAME Idira Thomas

8. (b) If veteran, name war NO 8. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race COL 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DEC. 10 1920  
(Month) (Day) (Year)

8. AGE: 19 26  
Years Months Days If less than one day  
hr. min.

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

10. Usual occupation DOMESTIC H. W.

11. Industry or business \_\_\_\_\_

12. Name EZEKIEL SIMONS

13. Birthplace ST CHARLES ARK  
(City, town, or county) (State or foreign country)

14. Maiden name MATTIE BAKER

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

16. (a) Informant Halls Rinnard  
(b) Address 909 OHIO S.E.

17. (a) BURIAL (b) Date thereof 2/20/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Park

18. (a) Signature of funeral director PEOPLES UND. CO

(b) Address 3100 FRANKLIN AVE  
(c) Date received from registrar FEB 19 1940

2/19/40

**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 Robert A. Powell,

Licensed Embalmer No. 3402

P. O. Address 3108 Franklin

**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.**