

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.

APR 13 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

9491

Registration District No. 791Primary Registration District No. 1003Registrar's No. 2974

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 18 days
 (Specify whether _____)
 In this community Unknown
 years, months or days

3. (a) PRINT FULL NAME Walter Paster

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

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife MARY 6. (c) Age of husband or wife if alive 19 years
 7. Birth date of deceased 2 27 23
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 _____ 28 _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MISS10. Usual occupation Laborer

11. Industry or business _____

12. Name Tom Paster13. Birthplace Unknown (City, town, or county) (State or foreign country)14. Maiden name Lizzie Brooks15. Birthplace Unknown (City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs Mary Paster(b) Address 2316 Spruce17. (a) Burial (b) Date thereof 3-30-40
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenwood Cemetery18. (a) Signature of funeral director Hermon J. Smith(b) Address 4247 W. Delatille19. (a) MAR 29 1940 (b) J. B. Paster
 (Date received local registrar) (Signature)

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. 2316 Spruce
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
 year 1940 hour 10:02 minute _____ A. M.

21. I hereby certify that I attended the deceased from March 9, 1940, to March 26, 1940;
 that I last saw him alive on March 26, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 4 mos

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature M. W. Allen (M. D. or other)Address 2601 N Whittier Date signed _____

