DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9512

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2995

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 1 mo 8 days (Specify whether years, months or days)
In this community Unknown Abt. 11 Years

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. 2228 Clark
(If rural, give location)

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

3. (a) PRINT FULL NAME MOSES FRAZIER

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Male

5. Color or race Col

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive Unknown

7. Birth date of deceased February 25, 1890 (Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 2 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Iona Williams
(b) Address 2228 Clark ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/40 (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis, Ill

18. (a) Signature of funeral director T. M. C. Green
(b) Address 3517 Laclede ave

19. (a) MAR 31 1940 (Date received local registrar) (b) J. F. Baldwin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27 year 1940 hour 2:30 minute P M.

21. I hereby certify that I attended the deceased from February 20, 1940, to March 27, 1940; that I last saw him alive on March 27, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia, Terminal	1-2das
Cardiac Hypertrophy	1-1½yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Bronchopneumonia
Cardiac Hypertrophy

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

23. Signature H. J. Lyman (M. D. or other)
Address 2601 N Whittier Date signed 3/30/40

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

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.

50M-5-17-39
Rev. 5-17-39
I X19511

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 P. M. Green

Licensed Embalmer No. 1173

P. O. Address 3517 Laclede Ave

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.