

13469

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3671

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 Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 Days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Richard Lee Harrell 640

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 _____

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

7. Birth date of deceased 3-19-40
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 21 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Connie Harrell

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

14. Maiden name Leola Fields

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

16. (a) Informant's own signature Arthur M. Stenard

(b) Address 2601 N Whittier

17. (a) Burial (b) Date thereof 4/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Geo. Hamilton

(b) Address Health Dept.

19. (a) APR 24 1940 (b) _____
(Date received local registrar) (Date received by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")

(d) Street No. 2330 Carr
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3rd day 30th
year 1940 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from 3-19- 1940, to 3-30- 1940;
that I last saw him alive on 3-30- 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pyelitis (Newborn)
non congenital, no stones

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 G.E. Peace (M. D. or other) _____

Address 2601 N Whittier Date signed 4-22-40

WRITE LEGIBLY—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.

1 X1311

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.