

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

13483

Registrar's No. _____

3685

MAY 15 1940

791

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST LOUIS MISSOURI
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: LEONARD
1100 N LEONARD AVE
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME LAUYA HUBBARD

8. (b) If veteran, name war NO 3. (c) Social Security No. NONE

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

8. (b) Name of husband or wife NONE 5. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased OCT 4 1861
 (Month) (Day) (Year)

8. AGE: Years 78 Months 6 Day 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE WORK

11. Industry or business _____

12. Name HENRY JAMES

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

14. Maiden name UNKNOWN

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

16. (a) Informant's own signature WILLIE TURNER

(b) Address 3100 N LEONARD AVE

17. (a) BURIAL (b) Date thereof 4-24-40
 (Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD

18. (a) Signature of funeral director C. W. ROBERTS

(b) Address 3035 LEONARD AVE

19. (a) APR 23 1940
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
 (c) City or town ST LOUIS 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1100 N LEONARD AVE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20 day April
 year 1940 hour 12 40 P minute _____ M.

21. I hereby certify that I attended the deceased from April 20
20, 1939 to April 20, 1940
 that I last saw her alive on April 20, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myo-Carditis
hypertensive, chronic

Due to _____
 Due to _____

Other conditions Chronic Rheumatism
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy 191

Duration _____
 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 [Signature] (M. D. or other) _____

Address 2742 1/2 Fairview Date signed _____

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.

REV. 5-17-39 I X10811

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 *Arthur H. Hilliard*

Licensed Embalmer No. *3389*

P. O. Address. *3028 Dickson St*

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.