

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **135**

1. PLACE OF DEATH:

(a) County **St. Louis County**
(b) City or town **Jefferson-Barracks**
(c) Name of hospital or institution: **Veterans Administration Facility**
(d) Length of stay: In hospital or institution **Admitted 4/15/40**
In this community **unknown**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **3333 Lucas Avenue**
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME

Robert W. Avery

8. (b) If veteran, name war **Spanish-American**

8. (c) Social Security No. _____

4. Sex **Male**
5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Nora**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **October 30, 1874**

8. AGE: Years **65** Months **5** Days **28**
If less than one day _____ hr. _____ min.

9. Birthplace **Charlotte, N.C.**

10. Usual occupation **Waiter**

11. Industry or business _____

MOTHER FATHER { 12. Name **Ed. Avery**
13. Birthplace **South Carolina**
14. Maiden name **Lou Chambers**
15. Birthplace **South Carolina**

16. (a) Informant **M. Schuller**
(b) Address **Clinical Clerk, VAF, Jeff. Bks., Mo.**

17. (a) **BURIAL** (b) Date thereof **5 1 40**

(c) Place: burial or cremation **JEFFERSON BARRACKS**

18. (a) Signature of funeral director **Peoples BURIAL League**

(b) Address **3100 Franklin**

19. (a) **APR 30 1940** (b) **C. R. Myers**

(Date received local registrar) (Registrar's signature)

B.C. (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28**, year **1940** hour **4:30** minute _____ a.m.

21. I hereby certify that I attended the deceased from **April 15**, 1940 to **April 28**, 1940; that I last saw him alive on **April 28**, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death **Nephritis, chronic, with marked nitrogen retention.**

Due to _____
Due to _____

Other conditions **Hypertrophy of prostate, severe with urinary retention.**

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

707 While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature **C. W. Hughes, M.D.** (M. D. or other) **Chief Medical Officer**
Address **Vet. Adm. Bldg., Jeff. Bks., Mo.** Date signed _____

Duration **unkn**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

OCT 3 0 1944

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 H. Powell

Licensed Embalmer No.

3402

P. O. Address

3100 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.