

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **16582**
 Registrar's No. **4060**

Registration District No. **791**

Primary Registration District No. _____

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 6 days
(Specify whether
 In this community Life
years, months or days)

8. (a) PRINT FULL NAME FLOYD ELLIOTT, JR **430**

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race and 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 Jan 2 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 2 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 Floyd Elliott
 { 13. Birthplace Hot Springs Ark
(City, town, or county) (State or foreign country)
 { 14. Maiden name Bessie Perry
 { 15. Birthplace Marshall Ark
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bessie Elliott

(b) Address 2953 Thomas St.

17. (a) _____ (b) Date thereof 3-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Hill 15-8-40

18. (a) Signature of funeral director A.P. Richardson

(b) Address 25 Glasgow

19. (a) MAY 6 1940 (b) _____
(Date received local registrar) (Signature of 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. 2953 Thomas
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
 year 1940 hour 9:05 minute _____ A. M.

21. I hereby certify that I attended the deceased from April 29, 1940, to May 4, 1940
 that I last saw him alive on May 4, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia **A**
 Duration 5 days

Due to _____

Due to _____

Other conditions Acute Nasopharyngitis 10 days
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 W.C. Peace (M. D. or other) _____
 Address 2601 N Whittier Date signed _____

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.

Certified Copy

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 *W. Richardson*

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.