

JUN 15 1940

791

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(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 Julian Floyd 430

3. (b) If veteran, name war _____ 3. (c) Social Security No. 709-12-0261

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Susie Floyd 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Newbury, S. C. So. Caro.
(City, town, or county) (State or foreign country)

10. Usual occupation R. R. porter

11. Industry or business _____

MOTHER FATHER { 12. Name Whit W. Floyd

13. Birthplace ? S. C.
(City, town, or county) (State or foreign country)

14. Maiden name Dicy Dunlap

15. Birthplace ? S. C.
(City, town, or county) (State or foreign country)

16. (a) Informant D. J. Floyd
(b) Address 4308 Maffitt, Apt. 10

17. (a) Removal (b) Date thereof 5/21/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Rock, Ark.

18. (e) Signature of funeral director Russell Und. Co.

(b) Address 2732 Pine St.

19. MAY 21 1940 (b) _____
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4468 Cook, Apt. 21
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19th
year 1940 hour 4 minute 35 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on [the date and hour stated above.

Immediate cause of death Cerebral Apoplexy.

Due to _____

Due to _____

Other conditions _____
(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 5

23. Signature _____ (M. D. or other)

Address _____ (Post signed)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DEC 2 1955

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 Joel Russell

Licensed Embalmer No. 4112

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.