

Registration District No. 7911

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: St. John's
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 9 days
(Specify whether _____)
In this community 4 yrs
years, months or days

3. (a) PRINT FULL NAME Irving Arrington Compton

3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-05-1032

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

6. (b) Name of husband or wife Marie 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased May 10 1890
(Month) (Day) (Year)

8. AGE: Years 50 Months 0 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Nashville, Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business Wabash Ry. Co.

12. Name Wm Compton

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

14. Maiden name Francis Ford

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

16. (a) Informant's own signature _____ (b) Date thereof May 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director _____ (b) Address East St. Louis, Ill.

19. (a) 5/21/40 (b) _____
(Date received local registrar) (Date of death)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4247 Blair Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1940 hour 1:05 PM minute _____ M.

21. I hereby certify that I attended the deceased from May 8 - 1940, to May 17 1940, that I last saw _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis (Phlebotomy)

Due to Phlebotomy

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 _____

23. Signature Cawhite (M. D. or other) _____
Address 1114 W. Third St. St. Louis, Mo. Date signed 5/8/40

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

MOTHER FATHER

17. (a) _____ (b) _____
(Date received local registrar) (Date of death)

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.

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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. 3162

P. O. Address E. St. Louis Ill.

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.