

No. 2  
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7-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

30697

State File No.

7974

Registration District No.

791

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County 1014n. Jefferson Ave.  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community 16 Yrs.  
years, months or days)

3. (a) PRINT FULL NAME Nancy Earsey

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 115-4673

4. Sex Female 5. Color or race col. 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Wray 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 10 1862  
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace West Point, Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Jim Brinkley  
13. Birthplace Miss.  
14. Maiden name Martha (unknown)  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Idel Williams  
(b) Address 1014n. Jefferson Ave.

17. (a) burial (b) Date thereof 9-25-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director G. T. Adams  
(b) Address 257 1/2 E. Madison

19. (a) SEP 25 1940 (b) 9/25/40  
(Date received local registrar) (Date of signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 21  
(If outside city or town limit, write "RURAL")

(d) Street No. 1014n. Jefferson  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19  
year 1940 hour 4 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from September 7  
1940 to September 19, 1940  
that I last saw her alive on September 19 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myo Terminal Pneumonia  
broncho

Duration

1 wk

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions myocardial Degeneration 18 mos.  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 93c

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 J. C. Sherard (M. D. or other) \_\_\_\_\_

Address 11635 a Carr Date signed 9-26-40

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

**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

*L. B. Boykin*  
*L. B. Boykin*

Licensed Embalmer No. \_\_\_\_\_

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.**