

No. 2
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17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH 1003

State File No. 34248

Registration District No. 791

Primary Registration District No.

Registrar's No. 8945

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

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:
Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community life years, months or days)

3. (a) PRINT FULL NAME Joseph Featherston

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

4. Sex M 5. Color or race N 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 July 5th 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 21 _____ hr. _____ min.

9. Birthplace St. Louis (City, town, or county) (State or foreign country) 0

10. Usual occupation _____

11. Industry or business _____

12. Name Joseph Featherston

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

14. Maiden name Emily Johnson

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

16. (a) Informant Florence D. Spotts
(b) Address 2601 N. Whittier

17. (a) _____ (b) Date thereof 10-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director W. J. Brudick
(b) Address City Health Dept

19. (a) OCT 30 1940 (b) W. J. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 11
(d) Street No. 4300 St. Ferdinand (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 26
year 1940 hour 10:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from Sept. 21, 1940 to Sept. 26, 1940
that I last saw him alive on Sept. 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 2 wks.

Due to _____
Due to _____

Other conditions Gastro-Intestinal Indigestion
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 W. J. Brudick (M. D. or other) _____
Address 2601 N. Whittier Date signed 10/1/40

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.