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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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36719

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 8992

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2305 Walnut St (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis 22 (If outside city or town limits, write "RURAL")

(d) Street No. 2305 Walnut 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? ~~Mathematics Physician~~ years.

3. (a) PRINT FULL NAME Geo. Washington

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Abt (Month) (Day) 1886 (Year)

8. AGE: Years Abt 54 | Months | Days | If less than one day hr. min.

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

10. Usual occupation nil

11. Industry or business 6

FATHER
12. Name unknown 1
13. Birthplace unknown 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Josephine Mundy

(b) Address 2305 Walnut St.

17. (a) (Burial, cremation, or removal) (b) Date thereof 10/14/40 (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutger

19. (a) NOV 1 1940 (Date received local registrar) (b) J. F. Bullock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3 year 1940 hour 4:30 minute P M.

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

Immediate cause of death Chronic Myocarditis Chronic Interstitial Nephritis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury 5

23. Signature Alfred J Perry (M. D. or other)

Address Deputy Coroner Date signed 10/12/40

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

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