

791

1003

FILED DEC 11 1940

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

I. 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 1da  
In this community Unk. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis xxx  
(If outside city or town limits, write "RURAL")  
(d) Street No. No Home  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25  
year 1940 hour 10:55 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from September 24, 1940 to Sept. 25, 1940  
that I last saw him alive on September 25, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease 22 5 years

Duration

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

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

Other conditions: \_\_\_\_\_  
(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. Allen (M. D. or other) \_\_\_\_\_  
Address 2601 N. Whittier Date signed 10-2-40

8. (a) PRINT FULL NAME John Thomas

3. (b) If veteran, name war Unknown 8. (c) Social Security No. Unk

4. Sex M 5. Color or race C 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. 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Abt. 76' hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name ?

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

14. Maiden name ?

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

16. (a) Informant Florence A. Spotts

(b) Address 2601 N. Whittier

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 10/5/40  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

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

(b) Address 2500 Rutger

19. (a) NOV 1 1940 (b) \_\_\_\_\_  
(Date received local registrar)

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

MOTHER FATHER

**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 with the above constitutes grounds for revocation of license.)**

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