

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.

30935

Registrar's No.

9008

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County _____
(b) City or town 22234 Carr St St Louis MO
(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 _____
years, months or days

3. (a) PRINT
FULL NAME

Martha Bynum

8. (b) If veteran, _____

name war _____

8. (c) Social Security

No. _____

4. Sex Female
5. Color or race Colored

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

6. (b) Name of husband or wife

Richard Bynum

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

7. Birth date of deceased

5
(Month)

12
(Day)

1863
(Year)

8. AGE:

Years

Months

Days

If less than one day

87

5

14

hr.

min.

9. Birthplace North Carolina

(City, town, or county)

(State or foreign country)

10. Usual occupation House Work

11. Industry or business _____

12. Name John Patterson

13. Birthplace North Carolina

(City, town, or county)

(State or foreign country)

14. Maiden name Jane Patterson

15. Birthplace North

(City, town, or county)

Carolina

(State or foreign country)

16. (a) Informant's own signature Lincoln Denmark

(b) Address 22234 Carr St St Louis MO

17. (a) Married

(b) Date thereof

11-1-1940

(Burial, cremation, or removal)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Bus Howe

(b) Address 2732 Dickson St

19. (a) NOV 1 1940

(b) _____

(Date received from registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County _____

- (c) City or town ST LOUIS 21

(If outside city or town limits, write "RURAL")

- (d) Street No. 22234 CARR ST

(If rural, give location)

- (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26 year 1940 hour 11 minute 45 M.

21. I hereby certify that I attended the deceased from Sept 20 to Oct 26, 1940; that I last saw her alive on Oct 26, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Myo-Carditis

Duration

Due to

Hypertension

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. H. Hall (M. D. or other) _____

Address 20415 Jefferson Date signed 10-31-40

(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, ~~only~~.

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.