

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37434

State File No. _____

Registrar's No. _____

9707

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis 1940
(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 3 hrs 45 min
(Specify whether)
 In this community 17 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 71
(If outside city or town limits, write "RURAL")
 (d) Street No. 2007 O'Fallon
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
 year 1940 hour 4:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from
November 22, 1940 to November 22, 1940;
 that I last saw him alive on November 22, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Diabetic Gangrene

Duration

4 mos

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:

Of operations _____

Of autopsy _____

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 _____

28. Signature E. A. M. C. Rouse
 Address 2601 N. Whittier Date signed _____

3. (a) PRINT FULL NAME

Arnold Williams

8. (b) If veteran S.S. 499-03-4950 (c) Social Security name war. No. UNK

4. Sex Male 5. Color Col 6. (a) Single, widowed, married, divorced _____
 race _____

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 6 1882
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>9</u>	<u>17</u>	hr. min.

9. Birthplace Little Rock Ark
(City, town, or county) (State or foreign country)

10. Usual occupation

Labor

11. Industry or business

MOTHER FATHER {
 12. Name Unknown 9
 13. Birthplace Unknown (State or foreign country)
 14. Maiden name Unknown 7
 15. Birthplace Unknown (State or foreign country)

16. (a) Informant's own signature Georgia Lewis

(b) Address 2007 O'Fallon

17. (a) Burial (b) Date thereof Nov 28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director F. A. Rouse

(b) Address 2915 Franklin

19. (a) NOV 27 1940 (b) _____
(Date received local registrar) (Signature)

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.

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.....

F. A. Gross

Licensed Embalmer No. *2913*

P. O. Address *2913 Franklin*

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.