

12-40  
17-39  
X23179

MAR 25 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4852  
Registrar's No. 1100

Registration District No. 791

Primary Registration District No. 1003

1. 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 1 yr 9 mos 3 da  
In this community 22 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000  
17  
219  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2730 Pine Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Gid Anderson  
3. (b) If veteran, name war Unk  
3. (c) Social Security No. Unk

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 9  
year 1941 hour 9:35 minute A M.

4. Sex Male  
5. Color or race Negro  
6. (a) Single, widowed, married, divorced Unk  
6. (b) Name of husband or wife Unknown  
6. (c) Age of husband or wife if alive Unk years  
7. Birth date of deceased April 21, 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 6, 1939, to January 9, 1941;  
that I last saw him alive on January 9, 1941;  
and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 9 Days 18  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Carcinoma of Lt Maxillary c metastasis of Carcinoma of Nasopharynx c metastasis  
Duration Approx 3 yrs

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

Due to Primary site cancer  
Due to \_\_\_\_\_

10. Usual occupation Laborer

Other conditions 550  
(Include pregnancy within 3 months of death)

11. Industry or business Unk

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

12. Name Nice Anderson

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

14. Maiden name Harriet Hacie

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

16. (a) Informant Florence A Spalls

(b) Address 2601 N Whittier

17. (a) \_\_\_\_\_ (b) Date thereof 1-11-41  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

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

(b) FEB 3 1941

19. (a) \_\_\_\_\_ (b) J. Bredock  
(Date received local registrar) (Registrar's signature)

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 D

23. Signature W.C. Howard (M. D. or other)  
Address 2601 N Whittier Date signed \_\_\_\_\_

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

---

---

**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, fact should be so stated above.**