

FILED JUL 21 1941 791
Registration District No. 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:
BARNES HOSPITAL ()
(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 **SIR GEORGE FREDERICK HUGGINS**

3. (b) If veteran, name war. **UNKNOWN** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife. **KATE HUGGINS** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **JUNE 22 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 11 15 hr. min.

9. Birthplace **ST. VINCENT & B. WEST INDIES**
(City, town, or county) (State or foreign country)

10. Usual occupation **MERCHANT**

11. Industry or business **136**

12. Name **WILLIAM HUGGINS**

13. Birthplace **ST. VINCENT & B. WEST INDIES**
(City, town, or county) (State or foreign country)

14. Maiden name **FLORENCE HUGGINS**

15. Birthplace **ST. VINCENT & B. WEST INDIES**
(City, town, or county) (State or foreign country)

16. (a) Informant **ARTHUR PERRY HUGGINS**

(b) Address **PORT OF SPAIN, TRINIDAD**

17. (a) **CREMATION** (b) Date thereof **6-7-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **VALHALLA CREMATORY**

18. (a) Signature of funeral director **Robert S. Hopper**

(b) Address **4700 Washington Ave.**

19. (a) **JUN 8 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **WEST INDIES** (b) County **000**
(c) City or town **TRINIDAD**
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? **YES** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **7**
year **1941** hour **8** minute **15** A. M.

21. I hereby certify that I attended the deceased from **MAY 7 1941** to **JUNE 7 1941**;
that I last saw him alive on **JUNE 7 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary embolism** Duration

Due to **Past op. plastic on left ureter -**

Due to **Obstruction left ureter at bladder wall**

Other conditions **caused by stricture**
(Include pregnancy within 3 months of death) **non malignant**

cause of same **unknown** PHYSICIAN

Major findings:
Of operations **Scar obstructing left ureter at bladder**
Of autopsy **Saddle pulmonary embolism**
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 **Russell J. Prider** (M. D. or member)
Address **BARNES HOSPITAL** Date signed **6-7-41**

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

20
99

JUL 3 1941

JUL 3 1941

APR 1952

APR 1952

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.

No Embalmed

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.