

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 23116
5468
Registrar's No. _____Registration District No. 7-1

Primary Registration District No. _____

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:
1026 NORTH 14th STREET
 (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)

8. (a) PRINT FULL NAME "DIED UNNAMED" Lacy.

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced S O

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

7. Birth date of deceased DECEMBER 13 1940
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days _____ If less than one day
6 hr. 30 min.9. Birthplace ST. LOUIS, Mo
(City, town, or county) (State or foreign country)10. Usual occupation NEW BORN

11. Industry or business _____

MOTHER FATHER
 { 12. Name MAJOR LACY
 { 13. Birthplace LAKE VILLAGE ARKANSAS
 (City, town, or county) (State or foreign country)
 { 14. Maiden name MABLE BROWN
 { 15. Birthplace PINE BLUFF ARKANSAS
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Major Lacy
(b) Address 1026 N. 14th St17. (a) REMOVAL (b) Date thereof DEC 13 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation ST. LOUIS UNIVERSITY MEDICAL18. (a) Signature of funeral director. SCHOOL(b) Address _____
 19. (a) JUL 2 1941 (b) J. F. Brubaker
(Date received locally) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1026 NORTH 14th STREET
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 13
year 1940 hour 6 minute 45 P. M.21. I hereby certify that I attended the deceased from DECEMBER 13
12:15 P.M., 1940, to _____, 19____;
that I last saw him alive on DECEMBER 13 3:00 P.M. 40
and that death occurred on the date and hour stated above.Immediate cause of death CEREBRAL HEMORRHAGEDue to PRECIPITATE (RAPID) LABOROther conditions ASPIRATION OF AMNIOTIC FLUID
(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 Joseph H. Roberts (M. D. or other) 10
Address _____ Date signed _____

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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.