

FILED JAN 24 1945
Registration District No. **91**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 mos. 19 days**
(Specify whether years, months or days)
In this community **45 years**

3. (a) PRINT FULL NAME **John Alphan**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **---**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Mamie Alphan** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Unavailable about 1856**
(Month) (Day) (Year)

8. AGE: Years **abt. 85** Months Days If less than one day hr. min.

9. Birthplace **Unknown / Mississippi**
(City, town, or county) (State or foreign country)

10. Usual occupation **nil**

11. Industry or business

12. Name **Richard Alphan**

13. Birthplace **Unknown / Mississippi**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Unavailable**

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

16. (a) Informant **Marjorie Caanan**

(b) Address **4345 Cook Ave.**

17. (a) **Burial** (b) Date thereof **12-2-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem.**

18. (a) Signature of funeral director **Chas. J. Gates**

(b) Address **4107 Finney Ave.**

19. (a) **Dec 1 1941** (b) **J. F. Budeck**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1104 Whittier St.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov. 27,** day **1941**
year hour **5** minute **10 P.M.**
Sept. 8, 1941

21. I hereby certify that I attended the deceased from **Nov. 27, 1941** to **Nov. 27, 1941**
that I last saw him alive on **November 27,** 19 **41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chromey Interstitial Nephritis**
Duration **Indef.**

Due to

Due to **131**

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 **H. J. ...** (M.D. or other)
Address **2601 Whittier** Date signed **12.1.41**

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

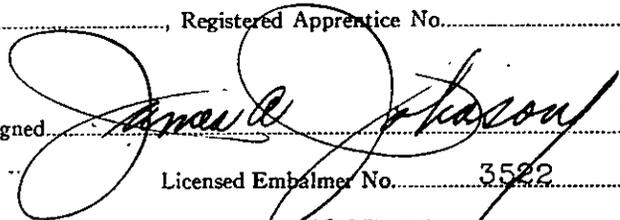
MOTHER FATHER

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.....

..... James A. Johnson, Registered Apprentice No.
working under my personal supervision.

Signed.....



Licensed Embalmer No. 3522.....

P. O. Address 4107 Finney Ave......

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.