

FILED APR 13 1942

Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 days
In this community 40 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dell May

3. (b) If veteran, name war No
3. (c) Social Security No. 499-01-8717

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

6. (b) Name of husband or wife CORA MAY
6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Dec 9 1899
(Month) (Day) (Year)

8. AGE: Years 42 Months 3 Days 16
If less than one day hr. min.

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

10. Usual occupation LABORER

11. Industry or business

12. Name SAMUEL MAY
13. Birthplace UNK UNK
(City, town, or county) (State or foreign country)

14. Maiden name SARAH MURPHY
15. Birthplace UNK UNK
(City, town, or county) (State or foreign country)

16. (a) Informant Cora May
(b) Address 2645 Spruce ST

17. (a) BURIAL (b) Date thereof MARCH 30 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FATHER DICKSON Cem.

18. (a) Signature of funeral director A. H. Beal
(b) Address 2736 LUCAS AVE

19. (a) MAR 27 1942 (b) J. F. Bredock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2645 Spruce
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26,
year 1942 hour 9 minute 00 A. M.

21. I hereby certify that I attended the deceased from March 4, 1942 to March 26, 1942.
that I last saw him alive on March 26, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease with Decompensation
Duration Unknown

Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 93 d 12 e 17 e

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 J. W. Johnson (M. D. or other) White
Address 2645 Spruce Date signed 3/27/42

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.....

Arthur L. Heilbard

Licensed Embalmer No.....

4221

P. O. Address.....

2649th Delmar Blvd

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.