

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2681

FILED APR 13 1942 91

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:  
Homer G. Phillips Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 26Hrs. 30min  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 18 009 17 9  
(c) City or town St. Louis  
(If outside city or town limits write "RURAL")  
(d) Street No. 325 S. Montrose Street  
(If rural, give location) \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Eddie James Washington

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 0

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

7. Birth date of deceased 1 6 42  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ - If less than one day 12 hr. 05 min.

9. Birthplace St. Louis 0 Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
{ 12. Name Clifford Washington  
{ 13. Birthplace Clinton Arkansas  
(City, town, or county) (State or foreign country)  
{ 14. Maiden name Sarah Hudson  
{ 15. Birthplace Columbus Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Mays Sherard  
(b) Address 2601 N. Whittier Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR 26 1942  
(Month) (Day) (Year)  
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. F. Bredbeck  
(b) Address City Health Dept

19. (a) MAR 25 1942 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 6  
year 42 hour 1 minute 20 P.M.

21. I hereby certify that I attended the deceased from 1-6-42  
Time 1:15 AM, 1942, to 1-6-Time 1-20 PM, 42  
that I last saw him alive on 1-6, 19 42  
and that death occurred on the date and hour stated above.

Immediate cause of death atelectasis Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_

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 DSM (M. D. or other) \_\_\_\_\_  
Address 2601 N. Whittier Street Date signed \_\_\_\_\_

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

20  
17  
9

1892

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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.**