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4-41
17-39
X29484

FILED JUN 10 1942

Registration District No. _____ Primary Registration District No. _____

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 Hillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 5 days
(Specify whether)

In this community 62 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
17

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")

(d) Street No. Jefferson & Delmar
(If rural, give location) 20

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Garratt

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, Single

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

7. Birth date of deceased December 9, 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28,
year 1942 hour 2 minute 40 P. M.

21. I hereby certify that I attended the deceased from March 23, 1942 to April 28, 1942; that I last saw him alive on April 28, 1942; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>4</u>	<u>19</u>	hr. _____ min.

Immediate cause of death Cerebral Thrombosis with Hemiplegia **Duration** 4 weeks

Due to Cerebral Hemorrhage

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Miss. (City, town, or county) _____ (State or foreign country) 1

10. Usual occupation Laborer

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown (City, town, or county) _____ (State or foreign country) 9

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) _____ (State or foreign country) 9

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. D. Egan (M. D. or other) _____
Address 2601 N. Whittier Date signed 4/30/42

16. (a) Informant Shirley Smith
(b) Address 2601 N. Whittier

17. (a) _____ (b) Date thereof 5-7-42
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. R. Rutter
(b) Address 3500 Rutter

19. (a) MAY 29 1942 (b) _____ (Registrar's signature)
(Date received local registrar)

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

MOTHER FATHER

a 14 347

4699

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16157
Registrar's No. 4690

Registration District No.

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:
Homer Phillips Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 3 days
(Specify whether
In this community 6 2 yrs
years, months or days)

3. (a) PRINT FULL NAME John Garratt

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased. Dec - 9 - 1871
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 11 (If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....
(b) Address.....

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

18. (a) Signature of funeral director.....

(b) Address.....
19. JUL 17 1942 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 22 Year 1942 hour 4:30 minute 40 P.M.

21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him/her live on....., 19..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

Duration
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?
..... (Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

1947

5-16157