

22727

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6427**

1. PLACE OF DEATH:

(a) County ~~St. Louis~~ **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: **Pro-Nominal Head at Home**  
(If not in hospital or institution, write street number or location) **Chicago**  
(d) Length of stay: In hospital or institution **NONE**  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

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. **809 N. JEFFERSON AVE**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **15**  
year **1943** hour **12** minute **55 AM**  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Cerebral hypoxia  
congenital polycystic**

Due to **Kidney**

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature **Alfred Perry** (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed **7/30/43**

3. (a) PRINT FULL NAME **William Early**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **NO**

6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive **NONE** years

7. Birth date of deceased **10th** (Month) **7th** (Day) **1897** (Year)

8. AGE: Years **44** Months **9** Days **6** If less than one day **NONE** min.

9. Birthplace **St. Louis** (City, town, or county) **MISSOURI** (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business **NONE**

12. Name **MAUDE EARLY**

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

14. Maiden name **MAUDE LEWIS**

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

16. (a) Informant **Ida Mae Jones**

(b) Address **3219 CASS AVE**

17. (a) **GREENWOOD Cem** (b) Date thereof **9-23-42**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **GREENWOOD CEMETARY**

18. (a) Signature of funeral director **Boyd Brock, Jr.**

(b) Address **3704 FINNEY AVE**

19. (a) **JUL 30 1943** (b) **J. F. Biedack**  
(Date received local registrar) (Registrar's signature)

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.....

*no Embalming*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address..... *[Signature]*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22727  
Registrar's No. 6427

Registration District No. 191 Primary Registration District No. 100 3

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:  
(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)

3. (a) PRINT FULL NAME William Early  
(b) If veteran, name war..... (c) Social Security No.....

4. Sex M 5. Color or race B 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..... (Month) (Day) (Year)

8. AGE: Years 44 Months 9 Days no (If less than one day) min.

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

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER { 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) (Burial, cremation, or removal)..... (b) Date thereof Jul-30-1942 (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) SEP 5 1942 (Date received local registrar) (b) J. J. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... Year..... hour..... minut..... M.

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Duration  
Immediate cause of death.....

Due to.....

Due to.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-22727