

FILED SEP 28 1943 318

Registration District No.

Primary Registration District No.

Registrar's No.

8321

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(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 8 days
In this community 21 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 1104 Hadley (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Elliott

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

4. Sex Male 5. Color of race Bl 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 Feb 18 1893
(Month) (Day) (Year)

8. AGE: Years 50 Months 6 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Jane
15. Birthplace Ark. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Bessie Rose

(b) Address 1517 G. Court

17. (a) Shipped (b) Date thereof Sept 20/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cremated Ark.

18. (a) Signature of funeral director J. W. [unclear]

(b) Address 2915 Franklin Ave

19. (a) SEP 20 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15,
year 1943 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from September
8, 19 43 to September 15, 19 43
that I last saw him alive on September 15, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Duration Unknown

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy _____

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. S. [unclear] (M. D. _____)
Address 2601 W. [unclear] Date signed 9/16/43

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 *G. H. [Signature]*

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

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.