

318

1002

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

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

(d) Length of stay: In hospital or institution 1 mo., 7 days
(Specify whether)

In this community 25 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL") 922

(d) Street No. 2665 Scott
(If rural, give location)

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

3. (a) PRINT FULL NAME William Lightner

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5,
year 1944 hour 11 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from January
27, 1944, to March 5, 1944;
that I last saw him alive on March 5, 1944;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negra 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: 4 13 1879
(Month) (Day) (Year)

Immediate cause of death: Bronchopneumonia
Carcinoma of Esophagus

Duration: Terminal
Unk.

8. AGE: Years 64 Months 10 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Labor

Due to _____

Due to _____

Other conditions: He
(Include pregnancy within 3 months of death)

11. Industry or business None

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Louise Toole

(b) Address 3317 Lawton

17. (a) Burial (b) Date thereof 3/10/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

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) _____ (e) Means of injury _____

18. (a) Signature of funeral director Wm. H. Jackson

(b) Address 215 So. Jefferson

19. (a) MAR 13 1944 (b) J. F. Budeck
(Date received local registry) (Registrar's signature)

23. Signature W. M. Jackson (M. D. or other) _____
Address 2601 W. 11th Date signed 3/2/44

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

2408
8072

2408
8072

680
95
57

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.....

S. J. Watson

Licensed Embalmer No.

2698

P. O. Address.....

2769 Chouteau

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.