

FILED DEC 9 1944 318
Registration District No.

Primary Registration District No.

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 0
(If not in hospital or institution, write street number or location)

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

In this community 19 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
13

(c) City or town St. Louis, 6
(If outside city or town limits, write "RURAL") 21

(d) Street No. 616 N. Garrison
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Robert Terrell

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

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

6. (b) Name of husband or wife Carried Mae Terrell 6. (c) Age of husband or wife if alive 1902 years

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

8. AGE: Years 42 Months 4 Days 19 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business John Terrell

12. Name Sorlow Ky.

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

14. Maiden name Mollie Terrell

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

16. (a) Informant Carrie Mae Terrell

(b) Address 616A North Garrison Ave

17. (a) Shipped (b) Date thereof Dec 1, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mounds, Ill.

18. (c) Signature of funeral director A. L. Bear Und Co.

(b) Address 2726 Lucas Ave.

19. (a) DEC 1 (b) J. F. Bredbeck
(Date of death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29,
year 1944 hour 11 minute 20 A. M.

21. I hereby certify that I attended the deceased from October 28, 1944 to November 29, 1944;
that I last saw him alive on November 29, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Pulmonary Tuberculosis (far advanced)

Duration Unk.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 12 1/2

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) (c) Means of injury 0

23. Signature Alva Mason (M. D.)
Address 2601 N. Harrison Date signed 11/30/44

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

MOTHER FATHER

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 Arthur L. Hoilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard St.

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.