S. No. 2
M—8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39934

Registration District No. FILED JAN 15 1945 18 Primary Registration District No. 1003 Registrar's No. 11143

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

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: Enroute to Hospital (If not in hospital or institution, write street number or location) Homer Phillips

(d) Length of stay: In hospital or institution -- (Specify whether In this community 25 years. 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mo

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17 10

(d) Street No. 4319a St. Louis Ave. (If rural, give location) 7

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

If yes, name country

3. (a) PRINT FULL NAME Sam Womack

3. (b) If veteran, name war ---

3. (c) Social Security No. 496-22-2492

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Viola Womack

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased August (Month) 5th (Day) 1897 (Year)

8. AGE: Years 47 Months 4 Days 21 ~~20~~ If less than one day hr. min.

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

10. Usual occupation Porter, Stationary

11. Industry or business McQuay-Norris Company

FATHER
12. Name Sam Womack
13. Birthplace Unavailable (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Lulu--Unavailable
15. Birthplace Unavailable (City, town, or county) Arkasaas (State or foreign country)

16. (a) Informant Viola Womack

(b) Address 4319a St. Louis Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-1944 (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Ave.

19. (a) (Date received local registrar) DEC 28 1944 (b) J. F. Buseck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26th year 1944 hour 12 minute 55 a M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to

Due to 94a

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 Patrick E. Taylor (M. D. or other) Dep Cor.

Address 1300 Clark Ave. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

Thomas J.Gates, Registered Apprentice No.

working under my personal supervision.

Signed Thomas Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.