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DEPARTMENT OF HEALTH
BUREAU OF THE CENTRAL
FILED JAN 25 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 158
Registrar's No. 399

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... St. Louis, Missouri
(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..... 1 mo. 18 days
In this community..... 52 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... Missouri (b) County.....
(c) City or town..... St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No..... 2717 Walnut
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... Mathew Compton
3. (b) If veteran, name war..... (c) Social Security No..... None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... January day..... 13,
year..... 1945 hour..... b minute..... 30 A.M.
21. I hereby certify that I attended the deceased from November 26, 1944 to January 13, 1945;
that I last saw h. im alive on January 13, 1945;
and that death occurred on the date and hour stated above.

4. Sex..... Male 5. Color or race..... Negro
6. (a) Single, widowed, married, divorced..... Widowed
6. (b) Name of husband or wife..... Unavailable
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... January 26th 1871
(Month) (Day) (Year)

Immediate cause of death..... Cerebro-vascular accident
Duration..... Unk.
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
73 11 17 hr. min.

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

10. Usual occupation..... Laborer

11. Industry or business..... Unavailable

MOTHER FATHER { 12. Name..... Unavailable
13. Birthplace..... " " " " (City, town, or county) (State or foreign country)
14. Maiden name..... " " " " (City, town, or county) (State or foreign country)
15. Birthplace..... " " " " (City, town, or county) (State or foreign country)

16. (a) Informant..... Kelton E. White
(b) Address..... 503 Locust Sbreet

17. (a) Burial..... (b) Date thereof..... 1/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director..... Charles J. Gates
(b) Address..... 4107 Finney Ave.

19. (a) JAN 15 1945 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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.....

23. Signature..... (M.D. or other).....
Address..... Date signed.....

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.....

Thomas J. Gates

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

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.