

FILED MAR 15 1945
Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 2198

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 27 days
In this community 8 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Steve Earl

3. (b) If veteran, name war No
3. (c) Social Security No. 497-16-9986

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

6. (b) Name of husband or wife Birdie Earl
6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased March 11 1889
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 23
If less than one day _____ hr. _____ min.

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

10. Usual occupation street cleaner

11. Industry or business _____

12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Birdie Earl

(b) Address 4006 Fairfax

17. (a) Burial (b) Date thereof 3-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Manuel

(b) Address 4059 Finney Ave.

19. (a) MAR 7 1945
(Date received local registrar) (Registrar's signature)

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. 4006 Fairfax
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4,
year 1945 hour 3 minute 50 A. M.

21. I hereby certify that I attended the deceased from February 5,
1945 to March 4, 1945;
that I last saw him alive on March 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration abt. 5 days

Due to _____

Due to _____

Other conditions Ca. of Stomach
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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 W.C. Calkaway (M. D. or other)
Address Abolwhittier Date signed 3/5/45

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.....

William S. McDowell, Registered Apprentice No.....
working under my personal supervision.

Signed: *William S. McDowell*

Licensed Embalmer No..... *2114*

P. O. Address.....

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.

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Steve Earl

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased March 11
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 3 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) MAD 40 1/2 1945 (Date received local registrar) J. F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

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 _____ (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

7049