S. No. 2
M—2-43
7. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22243

FILED AUG 3 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6483

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 14 days (Specify whether
In this community 6 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis, 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4417 Cote Brilliante 0 4
(If rural, give location)
(e) Citizen of foreign country? 6 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James McGee

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Colored

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased January 21, 1894 (Month) (Day) (Year)

8. AGE: Years 51 Months 5 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) La. 1 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name James McGee
13. Birthplace (City, town, or county) La. 1 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 0 (State or foreign country)

16. (a) Informant Shirley M. Smith
(b) Address Homer G. Phillips Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/45 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Y. B. Hudson
(b) Address City Health Dept

19. (a) 7/25/45 (Date received by local registrar) (b) J. F. Brenek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5, year 1945 hour 7 minute 00 A. M.

21. I hereby certify that I attended the deceased from June 21, 1945 to July 6, 1945; that I last saw him alive on July 5, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gumma of right eye	Unk.
Due to Erosion & destruction of soft palate and nasal septum (syphilis (autopsy)	Unk.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature T. P. Venable (M. D. or other)
Address 860 N. Whitten Date signed 7/4/45

(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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. aug

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6483

1. PLACE OF DEATH:

(a) County

(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)

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

3. (a) PRINT FULL NAME James McGee

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 21 1889
(Month) (Day) (Year)

8. AGE: Years 51 Months 5 Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

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

MOTHER
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) AUG 20 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5
year 1945 hour minute 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY