

FILED AUG 7 3-18

L 1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **6683**

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 **4 days**
(Specify whether years, months or days)

In this community **9 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **CCO**

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

(d) Street No. **453 Antelope**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James People**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male 2**

5. Color or race **Negro**

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

6. (b) Name of husband or wife _____

7. Birth date of deceased **July 13 1935**
(Month) (Day) (Year)

8. AGE: Years **10** Months **0** Days **15**
If less than one day _____ hr. _____ min.

9. Birthplace **Starksville Miss. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Student**

11. Industry or business _____

12. Name **James Peoples Sr.**

13. Birthplace **Starksville Miss. 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Alberta Nash**

15. Birthplace **Starksville Miss. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **James Peoples**

(b) Address **453 Antelope St.**

17. (a) **Burial** (b) Date thereof **7**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Chas. J. Gates**

(b) Address **4107 Finney Ave.**

19. (a) **JUL 30 1945** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **28,**
year **1945** hour **6** minute **00** A. M.

21. I hereby certify that I attended the deceased from **July 24,** 19 **45** to **July 28,** 19 **45**
that I last saw him alive on **July 28,** 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Miliary Tuberculosis (far advanced) Unk.**

Due to _____

Due to _____

Other conditions **27**
(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 **B. F. [Signature]**

Address **2601 N. Whittier** Date signed **7/30/45**

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.....

Thomas J. Gates.....

Registered Apprentice No.....

working under my personal supervision.

Signed.....


License 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.