

LED 8/8 1945
Registration District No.

Primary Registration District No. 1003

Registrar's No. 6988

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 3 days
(Specify whether
In this community 18 years
years, months or days)

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") 17 25
(d) Street No. 809 N. 15th St.
(If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Ellis Wyms

3. (b) If veteran, name war No 3. (c) Social Security No. 429-07-357

4. Sex M 7 5. Color or race Col 6. (a) Single, ~~widowed~~, married, divorced 0

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

7. Birth date of deceased. May 26 1916
(Month) 11 (Day) 1916 (Year)

8. AGE: Years 34 Months 8 Days 7 If less than one day hr. min.

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

10. Usual occupation DRIVER

11. Industry or business.....

MOTHER FATHER

12. Name Cust. WYMS

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

14. Maiden name LORAIN TAYLOR

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

16. (a) Informant Mrs. LORAIN WYMS

(b) Address 2204 SPURGE

17. (a) REMOVAL (b) Date thereof Aug. 8, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest City ARK

18. (a) Signature of funeral director [Signature]

(b) Address 4247 N. Lakeland Ave

19. (a) AUG 8 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6,
year 1945 hour 6 minute 35 A. M.

21. I hereby certify that I attended the deceased from August
3, 19 45 to August 6, 19 45;
that I last saw him alive on August 6, 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death..... Prob. Cerebro Embolism Duration 2 hrs.

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature [Signature] (M. D. or other)
Address 3601 Whittier Date signed 8/8/45

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

JUL 27 1950

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 *Lawrence E. Woodson*

Licensed Embalmer No. *4341*

P. O. Address *4431 Fairfield*

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.