S. No. 2
M—5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25897

State File No. 7650

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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

00
17
9

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 1 mo. 11 days (Specify whether
In this community 9 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 21

(c) City or town St. Louis, 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2126 Division 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Clarence Lomax Jr.

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 Married

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased November 22, 1915.
(Month) (Day) (Year)

8. AGE: 29 Years | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Clark Dale Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business

FATHER
12. Name Clarence Lomax (8)
13. Birthplace ~~Mississippi~~ Mississippi
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rosie Lee Hayes
15. Birthplace ~~Mississippi~~ Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Nella Lomax
(b) Address 2146 Division

17. (a) ~~Washington Park~~ Date thereof 9/1/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Missouri Undco.
(b) Address 2631 Gamble St.

19. (a) SEP 1 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26, year 1945 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from July 15, 1945 to August 26, 1945 that I last saw him alive on August 26, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia	5 days
Due to Splenomegaly with Prob. chr. malaria	Unk.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

28 d

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 R. E. Tisdale (M. D. or other)

Address 2601 N. Whittier Date signed 8/27/45

(Licensed Embalmer's Statement on Reverse Side)

MAY 5 1949

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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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.