No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 10 1945

State File No. 32533

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9413

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

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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: 914 Chambers st. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — (Specify whether
In this community 6 mos.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 001

(c) City or town St. Louis 25 17
(If outside city or town limits, write "RURAL")

(d) Street No. 914 Chambers st. 9
(If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME Lee Wynn

3. (b) If veteran, name war No

3. (c) Social Security No. 718-03-4184

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Divorced 3

6. (b) Name of husband or wife Anna Lee Wynn

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

7. Birth date of deceased Nov. (Month) 30 (Day) 1882 (Year)

8. AGE: Years 62 Months 10 Days 29 If less than one day hr. min.

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

10. Usual occupation R. Road Porter

11. Industry or business —

FATHER
12. Name Mike Wynn
13. Birthplace Starkville Miss. 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Eliza Williams
15. Birthplace Starkville Miss. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma L. Agnew
(b) Address 914 Chambers st.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-45 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Manuel
(b) Address 4059 Finney Ave.

19. (a) OCT 31 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29
year 45 hour 8 minute 33 A.M.

21. I hereby certify that I attended the deceased from Aug 1, 1945, to Oct-28-1945 that I last saw him alive on Oct-28-1945 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Failure & Heart

Due to Hypertension

Due to

Other conditions 73
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 W. A. Young (M. D. or other)

Address 2316 Market Date signed 10-30-45

(Licensed Embalmer's Statement on Reverse Side)

Emb separate Cert to be filed

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.