

FILED DEC 3 1945
318

Primary Registration District No.

1003

Registrar's No.

10330

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 Hrs. 35 Mins.
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 2/17
(If outside city or town limits, write "RURAL")
(d) Street No. 3018a Sheridan
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Infant Luster

3. (b) If veteran, name war. (c) Social Security No.

4. Sex Male 2- 5. Color or race Negro 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 10 24 45
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 hr. 35 min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Robert Luster

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

14. Maiden name Ocella Gray

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

16. (a) Informant Dr. W. M. Sheridan, M.D.
(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof NOV 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

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

19. (a) NOV 25 1945 J. F. Breda
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24
year 1945 hour 11 minute 54 P.M.

21. I hereby certify that I attended the deceased from 10:17 A.M.
10 - 24 45 to 11:54 P.M. 10 24 - 45

that I last saw him alive on 10 - 24, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Prematurity

Due to _____

Due to _____

Other conditions (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?
(Specify type of place)

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

23. Signature William A. Hubler (M. D. or other)
Address 2601 N. Whittier

Date signed 11-24-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
....., 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.