

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
STANDARD CERTIFICATE OF DEATH

State File No. **35996**
Registrar's No. **9664**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis
(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 Phillips Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 hours
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Paul White
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 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 Nov 25 1936
(Month) (Day) (Year)

8. AGE: Years 8 Months 11 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation School

11. Industry or business _____

MOTHER FATHER
12. Name Eddie White
13. Birthplace York Ala. 1
(City, town, or county) (State or foreign country)
14. Maiden name Callie Jackson
15. Birthplace Hollandale Miss 1
(City, town, or county) (State or foreign country)

16. (a) Informant Eddie White
(b) Address 1339 N. Garrison exp.

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

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director F. A. Green
(b) Address 296 Franklin ave

19. (a) NOV 8 1945 (b) J. F. Brewster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 2/1/1
(If outside city or town limits, write "RURAL")
(d) Street No. 1339 N Garrison 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 5
year 1945 hour 12 minute 35 P. M.
21. I hereby certify that I attended the deceased from 11-5- 1945 to 11-5- 1945;
that I last saw him alive on 11-5- 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Perforated Appendix with purulent Peritonitis
Duration Unk

Due to _____
Due to 12/1/1

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

Major findings:
Of operations _____
Of autopsy None

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 L. E. Courtney (M. D. or other) _____
Address 7607 N. Central Date signed 11/2/45

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 av

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.