V. S. No. 2
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ev. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 8 1946

State File No. 39030

Registration District No. 1003

Primary Registration District No.

Registrar's No. 11282

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 2815 Franklin
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Lester Commack

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 2

5. Color or race C

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife

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

7. Birth date of deceased September (Month) 24 (Day) 1944 (Year)

8. AGE: Years | Months 2 | Days 26 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Jesse Commack
13. Birthplace Tenn. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Mattie Belle Minor
15. Birthplace Jackson La. (City, town, or county) 1 (State or foreign country)

16. (a) Informant Mattie Belle Commack
(b) Address 2815 Franklin AVE.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Green Wood Cemetery

18. (a) Signature of funeral director F. A. Gilen
(b) Address 2915 Franklin ave

19. (a) DEC 24 1945 (Date received local registrar) (b) J. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20 year 1945 hour 1 minute 55 P M.

21. I hereby certify that I attended the deceased from 12-19, 1945, to 12-20, 1945; that I last saw him alive on 12-20, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

108

Major findings:
Of operations
Of autopsy Yes

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 L. E. Courtney (M. D. or other)

Address 3601 N Whitewell Date signed 12/22

(Licensed Embalmer's Statement on Reverse Side)

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 2910 Franklin Ave

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.