S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 13 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39129

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11363

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: Missouri Pacific Hosp
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Ala. (b) County 999

(c) City or town Mobile
(If outside city or town limits, write "RURAL") ONR

(d) Street No. Unk
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Alvin Faucett

3. (b) If veteran, name war Unk

3. (c) Social Security No. Unk

4. Sex M 2

5. Color or race Col. 9

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

6. (b) Name of husband or wife Unk.

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

7. Birth date of deceased Unk. (Month) — (Day) — (Year)

8. AGE: Years abt. 43 Months — Days — If less than one day hr. min.

9. Birthplace Mobile (City, town, or county) Alabama (State or foreign country)

10. Usual occupation Porter

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Knox Bros Und.
(b) Address 559 St Michael

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Mobile, Ala.

18. (a) Signature of funeral director A. L. Beal
(b) Address 27 26 Lucas

19. (a) DEC 26 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22d
year 1945 hour 5H0 minute a. M.

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

Immediate cause of death Tuberculosis of Cerebellum

Due to Pulmonary Tuberculosis

Due to

Other conditions
(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 Patrick E. Taylor Dep. Cor. (M. D. or other)
Address 1300 Clark Date signed 12/26/45.

(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 C. D. Richardson

Licensed Embalmer No. 2928

P. O. Address City

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.