DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 28 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

39867

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10958

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
I727 Belle Glade Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community I4 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 4 11

(d) Street No. I727 Belle Glade
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Alonzo Tillman Jr.

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 2

5. Color or race Col

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

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

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

7. Birth date of deceased Nov. 30. I945.
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days I4 If less than one day hr. min.

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

10. Usual occupation Nil.

11. Industry or business

FATHER
12. Name Alonzo Tillman Sr.
13. Birthplace Grace Miss. 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Jane
15. Birthplace Macon Miss. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Alonzo Tillman.
(b) Address I727 Belle Glade

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, I7. I945
(Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Wright's Funeral Home.
(b) Address 3I00 Easton Ave.

19. (a) DEC 17 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day I4
year I945 hour 10:00 minute P M.

21. I hereby certify that I attended the deceased from 11-30, 1945, to 12-14, 1945
that I last saw him alive on 12-14, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	12-14-45
Due to Difficult Delivery Prolonged Labor	11-30-45
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 J. C. Sherard (M. D. or other)

Address 2762 Franklin Date signed 12-15

(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 arthur L. Hilli

Licensed Embalmer No. 4221

P.O. Address 1154 Bay

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.