

No. 2
M-5-43
7-5-17-39
P I X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 20 1946 318
Registration District No. 318 Primary Registration District No. 1003
State File No. 7191
Registrar's No. 709

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:
St. Mary's Infirmary
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 40 years
years, months or days

3. (a) PRINT FULL NAME DAVID AARON
 3. (b) If veteran, name war --
 3. (c) Social Security No. 702-05-1371

4. Sex Male 2
 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Annie
 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased Sept. 29 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days 20
 If less than one day _____ hr. _____ min.

9. Birthplace Artesia Miss.
(City, town, or county) (State or foreign country)
 10. Usual occupation Chef-Private car-Wabash
 11. Industry or business ---

MOTHER FATHER
 12. Name Thomas Aaron
 13. Birthplace Unavailable Miss.
(City, town, or county) (State or foreign country)
 14. Maiden name Betty White
 15. Birthplace Unavailable Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Annie Aaron
 (b) Address 4509a Cottage Ave.
 17. (a) Burial Burial
(Burial, cremation, or removal) (b) Date thereof 1-23-46
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park
 18. (a) Signature of funeral director Chas. J. Gates
 (b) Address 107 Finney Ave.
 19. (a) JAN 22 1946 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4509a Cottage Ave.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19th
 year 1946 hour 8 minute 30 P.M.
 21. I hereby certify that I attended the deceased from Jan. 13th
1946 to Jan. 19th 19 46
 that I last saw him alive on Jan. 19th 19 46
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach
 Duration _____
 Due to _____
 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? _____

While at work? _____
(Specify type of place) (e) Means of injury _____
 23. Signature J. F. Brudick (M. D. or other) M.D.
 Address 2316a Market St. Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

6141

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.....

Thomas J. Gates....., Registered Apprentice No.....

^bworking under my personal supervision.

Signed..... *Thomas J. Gates*.....

Licensed Embalmer No. 4259.....

P. O. Address..... 4107 Finney 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.