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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

25748

FILED JUL 26 1946
318

JUL 26 1946
318

STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

Registrar's No. **6383**

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 (1)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **26 days**
31 yrs (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____

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

(d) Street No. **808 N Jefferson**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Henry Spinks**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **A. Spinks** 6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **December 1898**
(Month) (Day) (Year)

8. AGE: Years **54** Months **11** Days **8** If less than one day hr. _____ min. _____

9. Birthplace **Daleville, Miss**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Horace Spinks**

13. Birthplace **Daleville Miss**
(City, town, or county) (State or foreign country)

14. Maiden name **Leticia McWilliams**

15. Birthplace **Daleville Miss**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Spinks**
(b) Address **3429 Pine St**

17. (a) **Removal** (b) Date thereof **7-19-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Meridian, Miss**

18. (a) Signature of funeral director **Paul Jordan**

(b) Address **1245 Washington**

19. (a) **JUL 19 1946** (b) **J. F. Bredenk**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **July** day **13** year **1946** hour **10** minute **25** AM.

21. I hereby certify that I attended the deceased from **June 17, 1946** to **July 13, 1946**; that I last saw him alive on **July 13, 1946** and that death occurred on the date and hour stated above.

Immediate cause of death **Far-Advanced Pulmonary Tuberculosis** Duration **Unk**

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 **E. B. Williams** (M. D. or other) _____
Address **2601 N Whittier St** Date signed **7-15-46**

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

24597

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.....*Sheldon T. Yander*.....

Licensed Embalmer No. *4243*

P. O. Address *957 N. Elm*
Wichita, Kansas

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.