

7. S. No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22470**

FILED JUL 7 1947

100 Registrar's No. **3219**

Registration District No. **318** Primary Registration District No. _____

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

(d) Length of stay: In hospital or institution 1 Hr. 15 min.
(Specify whether years, months or days)

In this community _____
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 4112 St. Ferdinand
(If rural, give location)

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

3. (a) PRINT FULL NAME Melvin McNair Twin # 1

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

4. Sex 2 Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 6 6 47
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>1 hr. 15 min.</u>

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____ 9

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name Mary McNair

15. Birthplace Mount Olive Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur M. Sherard, Chgo.
(b) Address 2601 N. Whittier

17. (a) Anatomical Board Date thereof 6-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. Kelly
(b) Address 3500 Rutledge

19. (a) JUL 30 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 6
year 1947 hour 10:30 minute 55 P.M.

21. I hereby certify that I attended the deceased from 9:40 P.M.
6-6- 19 47 to 10:55 P.M. 1947;
that I last saw him alive on 6-6- 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Permataturity 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 W. H. Jankley (M. D. or other) _____
Address 2601 N. Whittier Date signed 6-10-47

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.