

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

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27795
7474
Registrar's No.

FILED SEP 7 1948

Registration District No.

Primary Registration District No. 1003

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

(d) Length of stay: In hospital or institution 3 mos 8 days
(Specify whether _____)

In this community 14 years
(years, months or days)

3. (a) PRINT FULL NAME Aaron Hendricks

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

name war _____

4. Sex Male 5. Color or race negro 6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Mrs. Nora Hendricks 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased 5 2 1900
(Month) (Day) (Year)

8. AGE: Years 48 Months 3 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Contractor

11. Industry or business Carpenter Work

12. Name Robert Henry Hendricks

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

14. Maiden name Sarah Moore

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

16. (a) Informant Nora Hendricks

(b) Address 1710 N. Taylor

17. (a) 1345126 (b) Date thereof 8-30-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director John H. L.

(b) Address 4059 E. 17th Ave.

19. (a) AUG 26 1948 (b) J. F. Buehler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County foo

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

(d) Street No. 1710 N Taylor
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1948 hour 10 minute 10 a.m.

21. I hereby certify that I attended the deceased from May 16, 1948, to August 24, 1948
that I last saw him alive on August 24, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus and Gangrene of left foot

Due to _____

Due to 61

Other conditions Postoperative Amputation
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

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 Charles N. Whittier (M. D. or other) _____
Address 2601 N Whittier Date signed 8/24/48

(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.....

W. Claude Gordon

Licensed Embalmer No.....

3489

P. O. Address.....

4675 Aldine

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.