

FILED DEC 31 1948

Registration District No. 377

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41976

Primary Registration District No. 3063

Registrar's No. 2838

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

1. PLACE OF DEATH

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Richard Chester

3. (b) If veteran name war World War I

3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife Rebecca Chester

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased December 1 1887
(Month) (Day) (Year)

8. AGE: Years 61 Months 0 Days 7 If less than one day
hr. _____ min. _____

9. Birthplace Jackson Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business _____

12. Name Samuel Chester

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

14. Maiden name Mollie Bernois

15. Birthplace Jackson Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Mollie Chester

(b) Address 490 Ziercher ave

17. (a) Burial (b) Date thereof 12-13-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director C. W. Roberts

(b) Address 1416 N. Taylor ave

19. (a) 12-9-48 (b) Shurid L. J. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town 490 Ziercher Ave.
(If outside city or town limits, write "RURAL")

(d) Street No. Clayton, Mo.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cause unknown

Due to _____
Due to _____ 900

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 D

23. Signature Shurid L. J. ... (M. D. or other) _____

Address Acting Commr. of Health Date signed 12-9-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

6
2
3

SEP 22 1950

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 Annie Roberts

Licensed Embalmer No. 4439

P. O. Address. 1416 N Taylor 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.