

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39375
State File No. 10105
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 0		d. STREET ADDRESS (If rural, give location) 17 So 22nd St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED a. (First) Joshua		b. (Middle) Townsil		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Nov. 21 1949		
5. SEX Male 2		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2		8. DATE OF BIRTH April 23, 1893		
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months 6		IF UNDER 24 HRS. Days 28		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME George Townsil		13b. MOTHER'S MAIDEN NAME Mary Banks		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Gladden 17 So. 22nd St.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bleeding Gastric Ulcer		Antecedent Causes Undetermined				Undet.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary Anemia					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		111	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 37401			

22. I hereby certify that I attended the deceased from **11-17**, 19**49**, to **11-21**, 19**49**, that I last saw the deceased alive on **11-21**, 19**49**, and that death occurred at **6:54a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Montague Laurence D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 11-22-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11/26/49		24c. NAME OF CEMETERY OR CREMATORY Boaker Washington Cen.	
24d. LOCATION (City, town, or county) (State) Centerville Twp. Ill.		25. FUNERAL DIRECTOR'S SIGNATURE R.M.C. Green		ADDRESS 3517 Locke Dr	
DATE REC'D BY LOCAL REG. NOV 25		REGISTRAR'S SIGNATURE J.B. Lasala			

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

Mel

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Melvin E. Green

Licensed Embalmer No. *4428*

P. O. Address *St. Louis, Mo*

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.