

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

42953
Do not use this space.

JAN 10 1938

791
1003

Registered No. 11205

1. PLACE OF DEATH

(a) County..... Registration District No.
(b) Township..... Primary Registration District No.
(c) City..... (d) Street No. *Eu Route City Hospital #1* St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. *2207 Chestnut* St. 21 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *✓*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 65 - - -

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Laborer*
9. Industry or business in which work was done, as saw mill, bank, etc. *✓*
10. Date deceased last worked at this occupation (month and year) *✓* 11. Total time (years) spent in this occupation *✓*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *P.A. Pa.*

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Pa.*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Pa.*

17. INFORMANT (ADDRESS) *O. Buzard - P.D. 1869 St. No 144*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *St. Louis 11 20 38*

19. FUNERAL DIRECTOR (ADDRESS) *St. Louis Medical College*

20. FILED *DEC 6 1937* *J. Bredek* Local Registrar.

No Physical Exam in attendance
MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11/11 1937*

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at *11:15* m.

The principal cause of death and related causes of importance were as follows:

Several apoplexy
arterio sclerosis
Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis? *✓* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *✓* Date of injury..... 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *See above*
Nature of injury *See above*

Was disease or injury in any way related to occupation of deceased? *No*
If so, specify.....

(Signed) *Joseph M. Quinn* M.D.
Deputy Coroner
(Address).....

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

243

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)