

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.

1939 JAN 17 1939

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

41204
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **1003**
 (b) Township Primary Registration District No. Registered No. **10896**
 or
 (c) City **St. Louis** (d) Street No. **City Hospital** 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Julian F. Muckerman
 (a) Residence, No. **4320 N. Newstead Av** St. **10** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 15th 1890**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
48 4 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Carpenter**
 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) **St. Louis 0**

FATHER 13. NAME **Edw. Muckerman 0**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis 0**

MOTHER 15. MAIDEN NAME **Frances Schwegman**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Washington, Mo.**

17. INFORMANT (ADDRESS) **Frances Muckerman 4320 N. Newstead Av.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Dec. 20 1938**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Promschurg Mnd. Co 4744 W. Florissant St.**

20. FILED **DEC 19 1938** **J. P. Budack** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12/17 1938**

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 **11:30 A**

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

Hemorrhage and shock during an operation for Pulmonary Tuberculosis at City Hosp #1, Dec. 17 1938
 Date of onset

Other contributory causes of importance:
Carcinoma of Lung 47B

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? **Yes**

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
 Nature of injury **4**

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify (Signed) **Regl. M. J. ...**
 (Address) **Deputy Grand**

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 Guy W Wilkerson

Licensed Embalmer No. 35-75

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, above space should be left blank.