

REC'D FEB 10 1939

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

236

Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No..... 791
 (b) Township..... / Primary Registration District No..... 1003
 (c) City..... St. Louis / (d) Street No. City Hospital No. 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. da.

D. 14238

2. PRINT FULL NAME

J. M. D.

John Mike

(a) Residence, No. 1129 South 10th St. 22 (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 (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 About 50.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Zoo Attendant
 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) Cyria 7

13. NAME John Mike 7

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cyria 7

15. MAIDEN NAME Josephine Unknown 7

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cyria 7

17. INFORMANT Hosp. Info M. Kent (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE Jan 9, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. D. Bruck 2906 Grand St. St. Louis, Mo. (Address)

20. FILED JAN 7 1939 J. D. Bruck (Address) City Hospital No. 1

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/5/39 19

22. I HEREBY CERTIFY, That I attended deceased from 12/31/38 19 to 1/5/39 19

I last saw him alive on 1/5/39 19 Death is said

to have occurred on the date stated above, a. p. m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of Rectum
 Intestinal obstruction
 Date of onset

Other contributory causes of importance:

Pentonitis acuta
 Name of operation Op. Colostomy Date of 1-1-39
 What test confirmed diagnosis? Biopsy 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.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) Albert H. Krause M. D.
 (Address) City Hospital No. 1

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.

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.....

Thos Luteis....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Thos Luteis*.....

Licensed Embalmer No. *1619*.....

P. O. Address *2906 Graves*.....

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.