

REC'D MAR 13 1939

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

4429

Do not use this space.

1122

Registered No.

## 1. PLACE OF DEATH

- (a) County..... Registration District No. 791  
1008  
(b) Township..... Primary Registration District No.  
(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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles DeLisle

- (a) Residence, No. 3400 So. Grand Blvd. St. 16  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Apr. 9, 1965.</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>9</u>	DAYS <u>22</u>
If LESS than 1 day, ..... hrs. or ..... min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Clerk</u>	
	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) <u>Florissant, Mo.</u> (STATE OR COUNTRY)		
FATHER	13. NAME <u>Leon DeLisle</u>	
	14. BIRTHPLACE (CITY OR TOWN) <u>Dont Know.</u> (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>Adeline Fortin</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>Dont Know.</u> (STATE OR COUNTRY)	
17. INFORMANT <u>Sister Seraphine</u> (ADDRESS) <u>3400 So. Grand Blvd.</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>SS. Peter &amp; Paul Cem.</u> DATE <u>Feb. 3, 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>J. H. Gebken &amp; Co.</u> (ADDRESS) <u>2842 Meramec St.</u>		
20. FILED <u>FEB 19 1939</u> <u>J. P. Baudich</u> Local Registrar.		

*The Physician's Certificate of Death*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/2/39 19

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 10:45 A.M.  
The principal cause of death and related causes of importance were as follows:  
Date of onset

Chronic Myocarditis  
Arterio Sclerosis

Other contributory causes of importance: None

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.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify.....  
(Signed) Joseph M. Gumbert M.D.  
(Address) Equity

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should 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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Herman A. Gebker*

Licensed Embalmer No. *312*

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

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

4429  
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. .... 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.

Registered No. 1122

2. PRINT FULL NAME Charles De Lisle

(a) Residence, No. .... St.  (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9 - 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 9 22

OCCUPATION  
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.  
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)

FATHER  
13. NAME

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

MOTHER  
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7/6/39 19 J. B. Budeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-2 1939

22. I HEREBY CERTIFY, That I attended deceased from

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

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

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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) Joseph W. Quinn, M. D.

(Address) Deputy Coroner

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-4429