

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.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS 791
CERTIFICATE OF DEATH**

4872
Do not use this space.

REC'D MAR 13 1939

1. PLACE OF DEATH

(a) County Registration District No.
 (b) Township Primary Registration District No.
 (c) City St. Louis (d) Street No. 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 August Okerman

(a) Residence, No. 1954 North Broadway St. 26 (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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 22, 1888

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	50	3	24	

OCCUPATION

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. Unemployed

10. Date deceased last worked at this occupation (month and year) 1938 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

FATHER

13. NAME Unknown

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT Laura Okerman
 (ADDRESS) 1954 North Broadway

18. BURIAL, CREMATION, OR REMOVAL
 PLACE St. Matthews DATE 2/18/39

19. FUNERAL DIRECTOR (NAME) A. T. McLaughlin
 (ADDRESS) 2301 Lafayette Ave.

20. FILED J. B. Redbeck
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 17, 1939

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

I last saw h. _____ alive on Jan. 29, 1939, 19____. Death is said to have occurred on the date stated above, at 8:37 PM.

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

Fracture of Skull and Severe Injury to the Brain when he slipped and fell at the end of Broadway Jan. 29, 1939 returned to the City Hospital Feb 14, 1939 without treatment for the same injury. Whether the death was due to this accident or not was ascertained by the coroner's jury.

Other contributory causes of importance:

the City Hospital Feb 14-1939 without treatment for the same injury. Whether the death was due to this accident or not was ascertained by the coroner's jury.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury 1/28/39
 Where did injury occur? Public Place (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. Juman, M. D.
 (Address) Deputy Coroner

FEB 17 1939

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.....

L. W. Cooper....., Registered Apprentice No.....
working under my personal supervision.

Signed *L. W. Cooper*.....

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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.