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.

REC'D MAR 9 1939

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

6914
Do not use this space.

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1. PLACE OF DEATH
(a) County JEFFERSON Registration District No. 425
(b) Township MERAMEC 1 Primary Registration District No. 5580 Registered No. 12-4
(c) City (d) Street No. ST. JOSEPH'S HILL INFIRMARY 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.

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2. PRINT FULL NAME JOHN C. SOMMERS
(a) Residence, No. ST. JOSEPH'S HILL INFIRMARY St.
(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: 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~~ STANISLAUS F. X. HEMP

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4 / 22 / 1872

7. AGE: YEARS 66 | MONTHS 10 | DAYS 4 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED AUTO SALESMAN
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) 1930
11. Total time (years) spent in this occupation 25

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO.

FATHER
13. NAME PETER C. SOMMERS 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

MOTHER
15. MAIDEN NAME KATE DONNELLY
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY

17. INFORMANT (ADDRESS) ST. JOSEPH'S HILL INFIRMARY By Brother Bonaventure

18. BURIAL, CREMATION, OR REMOVAL
PLACE CALVARY CEM. DATE MARCH 1, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. MULLEN UND. CO. 5165 DELMAR BLVD. ST. LOUIS

20. FILED 26 Feb 1939 James A. Townsend Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1939, to Feb 24, 1939
I last saw him alive on Feb. 24, 1939. Death is said to have occurred on the date stated above, at 4:25 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	

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

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Jesse S. Sargent, M. D.
(Address) Eureka, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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