

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 7 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26802 ✓

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1235

1. PLACE OF DEATH: St. Louis 3

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: Mount St. Rose Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME George J. Furry 600

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 5, 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	58	6	3	_____ hr. _____ min.

9. Birthplace Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business Shoe Store

12. Name Elijah Furry

13. Birthplace n Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Audie Klocke

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Connors

(b) Address 3815 Fillmore St. Burien

17. (a) _____ (b) Date thereof 7-11-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery Cullinane Bros.

18. (a) Signature of funeral director _____

(b) Address 1710 N. Grand Blvd.

19. (a) JUL 10 1939 (Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County _____

(c) City or town 3815a Fillmore St.
(If outside city or town limits, write "RURAL")

(d) Street No. St. Louis Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day _____
year 1939 hour 9:50 minute PM M.

21. I hereby certify that I attended the deceased from July 1st
_____ 1939, to July 8 1939
that I last saw him alive on July 8 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Inanition due to subnormal colitis

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury? _____

23. Signature B. C. Bauman (M. D. or other) _____
Address M. T. St Rose Care Date signed _____

U.K.

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.....

Fred Frick

Licensed Embalmer No. *3186*

P. O. Address.....

St. Louis Mo.

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.