

REC'D SEP 14 1939

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

27215
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 3
(b) Township 1 Primary Registration District No. 1003
(c) City St. Louis (d) Street No. Ben Beaudouin City Hospital Registered No. 6715
(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

(a) Residence, No. 2207 Chestnut St. 21 (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) Widowed

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. abt. 69

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc. None
10. Date deceased last worked at this occupation (month and year) None 11. Total time (years) spent in this occupation None

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 0

FATHER 13. NAME Unknown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " 9

MOTHER 15. MAIDEN NAME "

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

17. INFORMANT (ADDRESS) Joseph Beaudouin 6135 Leuch

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis DATE 7-5-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. R. R. 3000 Ruth

20. AUG 1 1939 903 Beudouin Local Registrar

~~NO MEDICAL CERTIFICATE RE DEATH~~

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/12/39

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw him 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 Chronic Myocarditis
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. Quinn, M.D. (Address) Deputy Coroner

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

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 comply with the above constitutes grounds for revocation of license.)

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