

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
SEP 14 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27439**
6939

Registration District No. **791** Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH: **1008**
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Josephine Hospital**
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Infant Filla 400**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**
4. Sex: **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 9, 1939**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

9. Birthplace **St. Louis** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER
12. Name **Joseph Filla**
13. Birthplace _____ **Mo.**
14. Maiden name **Josephine Richt**
15. Birthplace _____ **Mo.**

16. (a) Informant's own signature **Joseph Filla**
(b) Address **Pocahontas, Ill.**

17. (a) **Burial** (b) Date thereof **Aug. 10/39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.**
18. (a) Signature of funeral director **Gas. W. Clark**
(b) Address **1125 Hodiamont Ave**

19. (a) **AUG 10 1939** (b) **J. P. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **2**
(c) City or town **St. Louis** **NR**
(d) Street No. **Pocahontas, Ill.**
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **9**
year **1939** hour **2** minutes **45 P.M.**
21. I hereby certify that I attended the deceased from **this date**
19____ to **Aug. 9** 19____
that I last saw him alive on **Aug. 9** 19____
and that death occurred on the date and hour stated above. 19____

Immediate cause of death **Stillborn**
Duration _____

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) (d) Means of injury _____
23. Signature **D. C. Williamson** (M. D. or other) _____
Address **6336 Clayton Road** Date signed **Aug 9/1939**

Dr. O. E. Williamson
6536 Clayton Road
Hl. 5267 7-8pm.

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.....

Jas. W. Clark

Licensed Embalmer No. 1661

P. O. Address. 1125 Hodiament Ave.,

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.