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
[redacted] 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30587

Registration District No. 1003 Primary Registration District No. Registrar's No. 7650

1. PLACE OF DEATH:

(a) County St Louis Mo

(b) City or town City Hospital #1 (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital #1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis Mo (If outside city or town limits, write "RURAL") 6

(d) Street No. 1339 Aubert (If rural, give location)

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

3. (a) PRINT FULL NAME John W Theby 1 A

3. (b) If veteran, name war no

3. (c) Social Security No. 491-18-2418

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 43 years

7. Birth date of deceased 4/24/94 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	45	4	8	hr. min.

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

10. Usual occupation Plasterer

11. Industry or business

FATHER
12. Name John Theby
13. Birthplace Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Augusta Haas
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Theby

(b) Address 1336 Aubert

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/39 (Month) (Day) (Year)

(c) Place: burial or cremation ~~Peoples~~ St Paul Cemetery

18. (a) Signature of funeral director Peoples Bros

(b) Address 3029 Lafayette

19. (a) SEP 4 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2d day SEPT year 1939 hour 7 minute 40 A M.

21. I hereby certify that I attended the deceased from 6-11, 1939, to 9-2, 1939 that I last saw him alive on 9-2-, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of antrum	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Kenneth L. Carter (M. D. or other)

Address 1575 Lafayette Date signed 9/4/39

(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 comply wi the above constitutes grounds for revocation of license.)

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