DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D NOV 13 1939 791

Registration District No. 1008

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33963

Primary Registration District No.

Registrar's No. 8501

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.

1. PLACE OF DEATH:

(a) County: 2

(b) City or town: St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3946a DeTonty St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community: 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 1

(c) City or town: St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No.: 3946a DeTonty St. (If rural, give location)

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

3. (a) PRINT FULL NAME: Peter O. Hand 520

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Elizabeth Hand

6. (c) Age of husband or wife if alive: XXX years

7. Birth date of deceased: April (Month) 24 (Day) 1857 (Year)

8. AGE: Years 82 Months 5 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace: Osage County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Section Foreman

11. Industry or business: Frisco Railroad

FATHER
12. Name: Michael Hand
13. Birthplace: (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Rose Carroll
15. Birthplace: (City, town, or county) Ireland (State or foreign country)

16. (a) Informant's own signature: Peter Hand Jr.

(b) Address: 3946a DeTonty St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/4/39 (Month) (Day) (Year)

(c) Place: burial or cremation: Chamois, Mo.

18. (a) Signature of funeral director: E. J. Schmuke

(b) Address: 3125 Lafayette Ave.

19. (a) OCT 3 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2nd year 1939 hour 4 03 minute 9 M.

21. I hereby certify that I attended the deceased from 9/28/39, 19__, to 10/1, 1939; that I last saw him alive on 10/1, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	2 yrs.
Due to: Chronic Bronchitis	3 yrs.
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: Chas. O. [illegible] (M. D. or other) M.D.

Address: 3102 South Broadway Date signed: 10/2/39

(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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette ave.

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

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