DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34410

Registration District No. 1003 Primary Registration District No. _____ Registrar's No. 8948

1. PLACE OF DEATH: 1939 NOV 13

(a) County _____
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 hrs (Specify whether years, months or days)
In this community 15 yrs

2. USUAL RESIDENCE OF DEACESED:

(a) State Missouri (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1319a No 24th St
(If rural, give location)
(e) If foreign born, how long in U.S.A.? American Born years.

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3. (a) PRINT FULL NAME Charles Darnell

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Malinda Darnell

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased June 12th 1881 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
58	4	6	hr. min.

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

10. Usual occupation Janitor

11. Industry or business _____

FATHER
12. Name Willis Darnell
13. Birthplace LEXINGTON KY (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Manda
15. Birthplace Lexington, Ky (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address 1319a North 24th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/39 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Randle & Son
(b) Address 3133 Bell Avenue

19. (a) OCT 20 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18th day Oct year 1939 hour 4 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal Obstruction	
Due to: Post Operative Adhesions (Appendectomy)	
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 Joseph M. Lemm (M. D. or other)
Address Deputy Coroner Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

Rev. 8-1-39 1 x19511

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.

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. S Furaton

Licensed Embalmer No. 269 B

P. O. Address. 2769 Chouin

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.