

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.

Registration District No. **1003**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **Saint Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1910-A Cherokee Street.**
(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) **1910 Cherokee Street.**

NOV 13 1939

8. (a) PRINT FULL NAME **Joseph Ringhofer, Jr.**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Infant**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 23rd, 1939.**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	4	hr. min.

9. Birthplace **Saint Louis, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Joseph Ringhofer**

13. Birthplace **Saint Louis, Missouri.**
(City, town, or county) (State or foreign country)

14. Maiden name **Jean Hill**

15. Birthplace **Unknown Illinois.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Joseph Ringhofer**

(b) Address **1910-A Cherokee Street.**

17. (a) **Burial** (b) Date thereof **October 27, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cemetery**

18. (a) Signature of funeral director **Ziegenhain Bros.**

(b) Address **2623 Cherokee Street.**

19. (a) **OCT 27 1939** (b) **J. B. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County _____
(c) City or town **Saint Louis.**
(If outside city or town limits, write "RURAL") **[24]**
(d) Street No. **1910-A Cherokee Street.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **27th.**
year **1939.** hour **6** minute **25** A.M.

21. I hereby certify that I attended the deceased from **Oct 23**, 19**39**, to **Oct 27**, 19**39**
that I last saw him alive on **Oct 26**, 19**39**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Oblectasis
Due to **Premature birth**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 **F. W. [Signature] M.D.** (M. D. or other)

Address **3313 D Jefferson** Date signed **Oct 27/39**

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 W E Morris

Licensed Embalmer No. 3360

P. O. Address 2623 Cherokee

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.