

38409

State File No.

10248

Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH: IOWA

- (a) County _____
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Workhouse
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
 years, months or days)3. (a) PRINT Carnelius Ambrus
 FULL NAME 5163. (b) If veteran, _____ 3. (c) Social Security
 name war _____ No. _____4. Male 5. Color or Colored 6. (a) Single, widowed, married,
 race Colored divorced Single6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years7. Birth date of deceased Not Known
 (Month) (Day) (Year)8. AGE: Years _____ Months _____ Days _____ If less than one day
About 29 hr. _____ min. _____9. Birthplace Marvelle Ark
 (City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business _____

12. Name Jack Ambrus18. Birthplace Marvelle Ark.
Louis Patterson (State or foreign country)14. Maiden name Marvelle Ark.15. Birthplace _____
 (City, town, or county) (State or foreign country)16. (a) Informant's own signature Pauline Johnson(b) Address 3027 Franklin Ave.17. (a) Washington Uni (b) Date thereof Nov 30th 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Washington University18. (a) Signature of funeral director L. L. Beal Und Co.(b) Address 2726 Lucas Ave19. (a) NOV 30 1939 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town St. Louis, Mo. 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3027 Franklin Ave
 (If rural, give location)
 (e) If (green born, how long in U. S. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30
 year 1939 hour 3 minute 40 P M.

21. I hereby certify that I attended the decedent from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Lung Abscess
Pulm Tubercular
Exacerbation
1939Due to _____
 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 Deputy Registrar (M. D. or other)

Address _____

DEC 13 1939 791

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

Birdie Pearl Anderson

Licensed Embalmer No. *2929*

P. O. Address.....

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.