

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

DEC 13 1939 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38412
Registrar's No. 10251

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH: 1000

(a) County ST. LOUIS MO.
(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: Desloge Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hours.
(Specify whether years, months or days) 6 hr 13 min.

3. (a) PRINT FULL NAME John William Benz

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 _____

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

7. Birth date of deceased NOVEMBER 28 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. 13 min.

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Frank Joseph Benz
13. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

14. Maiden name MARIE VIOLET LAIR
15. Birthplace ATTON ILL.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Benz

(b) Address 7729 Water St

17. (a) _____ (b) Date thereof 12-1-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mattress

18. (a) Signature of funeral director Joseph Hudak

(b) Address 7430 Washington Ave
19. (a) NOV 30 1939 (b) J. B. Hudak
(Date received local registrar) (Registrar's signature)

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")
(d) Street No. 7729 Water Street.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1939 hour 3 minute 48 a. M.

21. I hereby certify that I attended the deceased from NOV 28
1939, to NOV 29, 1939.
that I last saw him alive on NOV. 29, 1939.
and that death occurred on the date and hour stated above.

Immediate cause of death prematurity Duration _____

Due to _____
Due to _____
Other conditions (include pregnancy within 8 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? 1

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph Hudak (M. D. or other) _____
Address Edmon Desloge Hospital Date signed _____

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 with the above constitutes grounds for revocation of license.)

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