

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.

DEC 9 - 1939

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1964

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Lemay Township  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
218 E. Etta  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community 25 yrs  
 years, months or days

3. (a) PRINT FULL NAME John Janning 552  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. unknown

4. Sex male  
 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Anna  
 6. (c) Age of husband or wife if alive 58 years  
 7. Birth date of deceased Feb 17 1878  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>8</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace St. Louis, Mo.  
 (City, town, or county) (State or foreign country) 0

10. Usual occupation Trimmer Factory work 0

11. Industry or business unemployed 6

MOTHER FATHER  
 { 12. Name John Janning  
 { 13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name Magdalena Bappert  
 { 15. Birthplace Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Emma Janning  
 (b) Address 218 E. Etta

17. (a) burial (b) Date thereof 11/10/39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Peter & Paul

18. (a) Signature of funeral director Fendler Und. Co.  
 (b) Address 7420 Michigan

19. (a) NOV 27 1939 (b) DR Meyer  
 (Date received locally) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis Co., Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 218 E. Etta, Lemay, Mo.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7  
 year 1939 hour 12 minutes 15 A. M.

21. I hereby certify that I attended the deceased from April 1939  
November 7, 1939 to \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 that I last saw h. im alive on November 6, 1939

Immediate cause of death Asphyxiation due to  
secondary aspiration of fluids  
following Cerebral hemorrhage  
Hypertention and nephritis  
 Duration 26 hrs

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (include pregnancy within 3 months of death)

Major findings:  
 Of operations None  
 Of autopsy None  
 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 A. G. White (M. D. or other) MD  
 Address 758 Lemay Ferry Rd Date signed 11-8-39

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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.....

*Clara Gendler*

Registered Apprentice No. *186*

working under my personal supervision.

Signed *Wilson Collins*

Licensed Embalmer No. *3887*

P. O. Address *Solomon M*

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

40907  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
(b) Township..... Primary Registration District No. 2.D.D. Registered No. 1964  
(c) City..... (d) Street No..... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John J. Janning

(a) Residence, No. [ ] St. [ ] (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 7 1934

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 61 8 29

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

Asphyxiation due to aspiration of fluid following cerebral hemorrhage with arteriosclerosis  
Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance: Nephritis Chronic

13. NAME

Name of operation 121 Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

24. Was disease or injury in any way related to occupation of deceased? If so, specify \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

(Signed) J. H. White M. D.  
(Address) 758 Lemay Ferry Rd.

20. FILED \_\_\_\_\_ 19\_\_\_\_ Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AND PRESCRIBED BY LAW.  
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very in part.

SUPPLEMENTARY

