

JAN 12 1940
Registration District No. 5001

Primary Registration District No.

1. PLACE OF DEATH: 1003
(a) County 1
(b) City or town ST. LOUIS
(c) Name of hospital or institution FIRMIN DESLOGE HOSPITAL
(d) Length of stay: In hospital or institution 19 DAYS
In this community _____
years, months or days

8. (a) PRINT FULL NAME ASA MAHOOD 3600
(b) If veteran, name war _____ (c) Social Security No. 346-07-2253

4. Sex MALE 5. Color or race WHITE
6. (b) Name of husband or wife MARY 6. (a) Single, widowed, married, divorced DIVORCED
7. Birth date of deceased JULY 14 1899
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	41	5	2	hr. min.

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

10. Usual occupation LABORER

11. Industry or business _____
12. Name EDWARD MAHOOD
13. Birthplace PENN. (City, town, or county) (State or foreign country)
14. Maiden name MARY MAHOOD
15. Birthplace INDIANA (City, town, or county) (State or foreign country)

16. (a) Informant's own signature WESELY MAHOOD
(b) Address CENTER, MO

17. (a) REMOVAL (b) Date thereof 12-19-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CENTER, MO

18. (a) Signature of funeral director A. H. HOPPE
(b) Address 4700 WASHINGTON AVE

19. (a) DEC 18 1939 (b) J. B. BUDICH
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State MISSOURI (b) County _____
(c) City or town CENTER NR
(d) Street No. R. R.
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month DECEMBER day 16
year 1939 hour 11 minute 57 P.M.

21. I hereby certify that I attended the deceased from NOVEMBER 27 1939 to DECEMBER 16 1939; that I last saw him alive on DECEMBER 16 1939; and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC MYELOGENOUS LEUKEMIA
Duration UNCERTAIN
Due to _____
Due to _____
Other conditions NONE
(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: No
(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? No (Specify type of place) (e) Means of injury 1
23. Signature George P. Oppenheimer (M. D. or other) MD
Address 1325 SOUTH GRAND BLVD. Date signed 12/17/39

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.

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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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Guy W. Wilkinson

Licensed Embalmer No. 3575

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.