

EC 14

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
JAN 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44549

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 2201

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 1 week
 In this community 14 years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town Kirkwood
 (If outside city or town limits, write "RURAL")
 (d) Street No. 615 Woodbine
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 34 years. years.

3. (a) PRINT FULL NAME Leo Dahl
 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 married
 6. (b) Name of husband or wife Etta Williamson Dahl
 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased Nov. - 15-1877-1878
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 14
 year 1939 hour 7 minute :45 A.M.
 21. I hereby certify that I attended the deceased from 11-7-39
 to 12-14-39
 that I last saw im alive on 12-14-39
 and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 0 Days 29
 If less than one day hr. min.

Immediate cause of death Staphylococcus Septicemia -
 Duration 1 wk
 Due to Ophthalmia and Urinary abscess. 5 mo.
 Due to _____

9. Birthplace Germany
 (City, town, or county) (State or foreign country)
 10. Usual occupation nil.

Other conditions Osteo-arthritic 1 yr.
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name Henry Dahl
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Augusta Moenig
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
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16. (a) Informant's own signature Etta Dahl
 (b) Address Etta 615 Woodbine Kirkwood
 17. (a) Sancti Burial (b) Date thereof 12/16/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sancti
 18. (a) Signature of funeral director Southern Funeral Home
 (b) Address 6322 So. Grand Blvd
 19. DEC 14 1939 by M. M. May
 (Date received local Registrar) (Registrar's signature)

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 Martin M. May (M. D. or other) M.D.
 Address St. Louis G. Hosp Date signed 12/14/39

See affidavit no 239 misc file

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 Vergil Benyman
Licensed Embalmer No. 1504
P. O. Address 1329 So Grand

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.