9 - 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44574

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 2157

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 stillborn (Specify whether In this community ..... 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. 326 W. Rose Hill (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Bohrer, Baby Boy 660

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex male 5. Color or race wh. 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased July 23 (Month) (Day) 1939 (Year)

8. AGE: Years stillborn Months Days If less than one day ..... hr. ..... min.

9. Birthplace Clayton (City, town, or county) Mo. (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

FATHER
12. Name Charles Bohrer
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Beatrice Guyer
15. Birthplace unknown (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Charles Bohrer

(b) Address 326 W. Rose Hill Kirkwood

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-25-39 (Month) (Day) (Year)

(c) Place: burial or cremation Washington U. Pathological Dept.

18. (a) Signature of funeral director St. L. Co. Hospital

(b) Address Clayton, Mo.

19. (a) DEC 9 - 1939 (Date received local registrar) (b) N. R. Meyer M.D. P.H. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1939 hour 1 minute 55 A. M.

21. I hereby certify that I attended the deceased from 7/23/39 ....., 19...., to 7/23/39, 19....; that I last saw him alive on stillbirth, 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Stillborn	7-23-39
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature N. Horth (M. D. or other) MD

Address County Hospital Date signed 7-24-39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 6-17-39 1 X19511

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 wit the above constitutes grounds for revocation of license.)

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