

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 305
Registrar's No. 305

Registration District No. 1000 Primary Registration District No. _____

1. PLACE OF DEATH: 1
 (a) County _____
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital, #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Days
 (Specify whether _____)
 In this community _____
 years, months or days _____

3. (a) PRINT FULL NAME Deppe, Tony
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 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: April 16, 1874
 (Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____
 12. Name Adam Deppe
 13. Birthplace Germany (City, town, or county) (State or foreign country)
 14. Maiden name Gertrude Niedick
 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Hackenwert
 (b) Address 5093 N. Union Blvd.,

17. (a) Burial (b) Date thereof 1-13-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Stroot-Carroll
 (b) Address 4600 Natural Bridge

19. (a) JAN 11 1940 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis 26
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1412 Monroe St.
 (If rural, give location) _____
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10,
 year 1940 hour 11:35 minute A. M.
 21. I hereby certify that I attended the deceased from January
7, 1940, to January 10, 1940
 that I last saw him alive on January 10, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration _____

Due to _____
 Due to _____
 Other conditions Leukic Heart Disease
 (Include pregnancy within 3 months of death)
hypertensive

Major findings: arteriosclerosis
Enlarged Heart
 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature [Signature] _____
 Address 1515 Lafayette, _____
 _____ Date signed 1/10/40

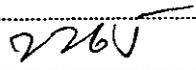
STATEMENT BY LICENSED EMBALMER

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.