

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 769769  
769Registration District No. 7917Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County \_\_\_\_\_
- (b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: City Hospital.  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)
- In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME John D. Follin. 45113. (b) If veteran, name was None 8. (c) Social Security No. None.4. Sex Male 5. Color or race White. 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Husband, (c) Age of husband or wife if alive Unknown years7. Birth date of deceased March 14th, 1874.  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
65 10 9 hr. min.9. Birthplace St. Louis Missouri.  
(City, town, or county) (State or foreign country)10. Usual occupation Unemployed.

11. Industry or business \_\_\_\_\_

12. Name George Follin.13. Birthplace Unknown. (State or foreign country)14. Maiden name Unknown. (State or foreign country)15. Birthplace Unknown. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Wm. Follin.(b) Address 3740 N. 9th. St.17. (a) Burial (b) Date thereof 1-27-40.  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Friedeins Cem.18. (a) Signature of funeral director Hy. Leidner and Co.(b) Address 1417 N. Market St.19. (a) JAN 25 1940 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri. (b) County \_\_\_\_\_
- (c) City or town St. Louis. 11  
(If outside city or town limits, write "RURAL")
- (d) Street No. Ozman Shelter.  
3225 B. Montgomery. (If rural, give location)
- (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23rd  
year 1940 hour 11:50 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Broncho Pneumonia  
(Primary)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature Alfred Perry (M. D. or other) \_\_\_\_\_Address 1417 N. Market St. Date signed 1-25-40

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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 Walter L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis Ave

**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.**