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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5130

FILED MAR 12 1940

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 1960

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4037 Easton Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community None
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St.Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4037 Easton Ave
(If rural, give location)

NOPHYSICIAN IN ATTENDANCE

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

3. (a) PRINT FULL NAME William Hollis

3. (b) If veteran, name war None

3. (c) Social Security No. 493-01-9583

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Lily Hollis

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years About 60 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business General Cable Co

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

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. J. Perry
(b) Address Coroners Office

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette Ave

19. (a) FEB 27 1940 (Date received local registrar) J. F. Bedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24th year 1940 hour 8:10 minute A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Fibrous Myocarditis; With Coronary Sclerosis;	
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 A. J. Perry (M. D. or other)
Address Deputy Coroner Date signed 2.27.40

(Licensed Embalmer's Statement on Reverse Side)

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. Frank D. Evans

Licensed Embalmer No. 2245

P. O. Address. St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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