E16680

MARGIN RESERVED FOR BINDING

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.

50M-5-17-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8755

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2238

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 St Louis City Hosp # 11 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community 75 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis 3 (If outside city or town limits, write "RURAL")

(d) Street No. 6122 Hoffman (If rural, give location)

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

3. (a) PRINT FULL NAME Peter Genin

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 ~~Annie~~ Anna Vogt Genin

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Oct (Month) 16 (Day) 1853 (Year)

8. AGE: Years 86 Months 4 Days 18 If less than one day hr. min.

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

10. Usual occupation Retired Laborer

11. Industry or business Quick Meal Stove Co

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

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

16. (a) Informant's own signature Anna Genin

(b) Address 6122 Hoffmann

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul Ch'yard

18. (a) Signature of funeral director Witt Bros. L & Ud.

(b) Address 2929 S. Jefferson Av.

19. (a) MAR 6 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4, year 1940 hour 10:10 minute A. M.

21. I hereby certify that I attended the deceased from March 3, 1940, to March 4, 1940 that I last saw him alive on March 4, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis Broncho pneumonia	yrs.
Due to Arteriosclerotic Heart Disease	
Due to 93C	
Other conditions Chronic pyelonephritis (Include pregnancy within 3 months of death) Non calculous	
Major findings: Of operations	
Of autopsy Myocarditis - arteriosclerosis pyelonephritis	

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 [signature] (M. D. or other)

Address 1515 Lafayette Date signed 3/4/40

(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 Paul A. Shanklin, Registered Apprentice No. ....., working under my personal supervision.

Signed Paul A. Shanklin

Licensed Embalmer No. 3472

P. O. Address 2929 S. Jefferson

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.