

No. 2
-10-39
17-5
X21

MAY 15 1940
Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community Life
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. 6434 Vermont ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

8. (a) PRINT FULL NAME Frank H. Michel **240**

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Daisy E. Michel 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased October 23 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 26 hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Proprietor

11. Industry or business Michel Bros. Hdwe. Co.

12. Name William F. Michel

18. Birthplace Germany

14. Maiden name Mary Linford

15. Birthplace England

16. (a) Informant Daisy E. Michel

(b) Address 6434 Vermont ave.

17. (a) Burial (b) Date thereof April 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director C. Hoffmeister & Co.

(b) Address 7814 S. Broadway

19. (a) APR 20 1940 (b) _____
(Date received local registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1940 hour 1 minute 10 p. M.

21. I hereby certify that I attended the deceased from April 8th 1940 to April 19th 1940

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 days

Due to Enlarged prostate or prostatitis

Due to _____
Other conditions Apastic Colitis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 H. M. Coffman (M. D. or other)

Address 6607 Vassar Date signed 4/20/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 the above constitutes grounds for revocation of license.)

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