

No. 2
11-10-39
5-17-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13675

MAY 15 1940 791

1003

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 3877

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: City Hospital
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days 2511

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis xxx
(d) Street No. No Home
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William Council

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 Single

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

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

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

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

10. Usual occupation Labourer

11. Industry or business _____

12. Name Unknown

13. Birthplace _____ (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Sam Butler - P.D.
(b) Address 441 47th St. St. Louis, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) _____ (Month) _____ (Year) _____

18. (a) Signature of funeral director Joseph M. ...
(b) Address 3100 Rutger

19. (a) APR 30 1940 (b) _____
(Date received by local registrar) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 27
year 1940 hour 11:15 minute A M.

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

Immediate cause of death Coronary Occlusion

Due to with Chemia
Due to Interstitial Myocarditis

Other conditions Chronic Interstitial
(Include pregnancy within 3 months of death)

Major findings: Kept
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 5

23. Signature Joseph M. ...
Address Deputy

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 with the above constitutes grounds for revocation of license.)

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