

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS
JUN 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4327

1. PLACE OF DEATH: St. Louis. /

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.

(c) Name of hospital or institution City Infirmiry.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution January 28, 1937

10yrs. (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis.

(c) City or town St. Louis, 13

(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.

(If rural, give location)

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

3. (a) PRINT FULL NAME Jacob King, 52A

8. (b) If veteran, name war No

8. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14,

year 1940. hour 2:00 minute _____ p. M.

4. Sex Male

6. Color or race White

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

6. (b) Name of husband or wife Bessie

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

7. Birth date of deceased Nov. 24, 1880

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 28,

1937 to May 14, 1940.

that I last saw him alive on May 14, 1940

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

8. AGE: Years _____ Months 5 Days 20

If less than one day _____ hr. _____ min.

9. Birthplace Cincinnati, Ohio.

(City, town, or county) (State or foreign country)

Immediate cause of death Degenerative Heart Disease

Due to Arteriosclerosis.

10. Usual occupation No Occupation.

11. Industry or business Unknown

Due to Chronic myocarditis.

Other conditions (include pregnancy within 3 months of death) _____

MOTHER FATHER

12. Name _____

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county) (State or foreign country)

Major findings: None

Of operations _____

Of autopsy None.

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature J. McLaughlin

(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof 5/16/40

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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? _____

18. (a) Signature of funeral director J. E. [Signature]

(b) Address 2301 Lafayette Avenue

19. (a) MAY 15 1940 (b) _____

(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature James T. [Signature] (M. D. or other)

Address 5800 Arsenal St. Date signed 5-15-40

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.

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

L. R. Casper

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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.