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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17121**
Registrar's No. **4602**

Registration District No. **791**

Primary Registration District No. **1003**

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

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:
5824 Dressell Ave. **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME **John H. Lloyd** **300**
(b) If veteran, name war **None** (c) Social Security No. **493-05-9795**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**
6. (b) Name of husband or wife **Mary Ann Lloyd** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **July 19th, 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 **10** **5** hr. _____ min.

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

10. Usual occupation **Waiter**

11. Industry or business _____
MOTHER FATHER { 12. Name **William Unknown**
13. Birthplace **Canada**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine Farrington**
15. Birthplace **N.Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Ann Lloyd**
(b) Address **5824 Dressell Ave.**

17. (a) **Calvary** (b) Date thereof **5-27-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **MAY 25 1940** (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** **7**
(If outside city or town limits, write "RURAL")
(d) Street No. **5824 Dressell Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **24** - **1940**
year **1940** hour **6** minute **30** P. M.
21. I hereby certify that I attended the deceased from **March**
28 - **1940** to **May 24** - **1940**
that I last saw him alive on **May 22** - **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Empty stomach gangrene right thigh and leg.**
Due to _____

Due to **Osteomyelitis middle 3rd right femur**
Other conditions **Nox tubercular**
(Include pregnancy within 3 months of death)

Major findings: **154**
Of operations _____
Of autopsy _____

Duration **10 days**
About 3 months
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Peter Beck, M.D.** (M. D. or other) _____
Address **4701 St Louis Ave.** Date signed **5/24/40**

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..... *W H Van Matre*.....
Licensed Embalmer No. *2825*.....
P. O. Address *4340 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.