

Registration District No. _____ Primary Registration District No. **1003**

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

3. (a) PRINT FULL NAME **Tom Latimer**
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 **70** Months _____ Days _____ If less than one day _____ min.

9. Birthplace **New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

MOTHER, FATHER
12. Name **Unknown**
13. Birthplace _____
14. Maiden name _____
15. Birthplace _____

16. (a) Informant's own signature **Louis Schopf**
(b) Address **5868 Foreman**
17. (a) _____ (b) Date thereof **5/27/50**
(c) Place: burial or cremation **St. Louis**

18. (a) Signature of funeral director **W. K. Rutter**
(b) Address **3500 Rutter**
19. (a) **JUN 3 1940** (b) **J. F. Dredel**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **2214 So Broadway**
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **26**
year **1940** hour **11:25** minute **P.** M.

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

Immediate cause of death _____
Due to **Spina**
Due to **Chronic Interstitial**
Other conditions **Hepatitis**
Major findings: **None**
Of operations _____
Of autopsy _____

Duration

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? _____
(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 **John M. ...** (M. D. or other)
Address **Deputy Coroner**

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.....

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.