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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23875

State File No.

6320

AUG 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

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:
1804 So. Tenth Street 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 1804 So. Tenth Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 27 day _____
year 1940 hour 8 PM minute _____ M.

21. I hereby certify that I attended the deceased from
July 10, 1940, to July 26, 1940;
that I last saw h. alive on July 26, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Essential thrombosis (left)
following fracture neck of femur 2 mo
Due to _____ (R)
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Fracture neck of femur (R side)
Of autopsy _____
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) accident
(b) Date of occurrence July 27
(c) Where did injury occur? at home (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? no (Specify type of place)
(e) Means of injury fall

23. Signature J. M. Tracy (M. D. or other)
Address 652 So. Grand Date signed July 28 1940

3. (a) PRINT FULL NAME FLORA TURNER 656

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Feb. 24 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 5 3 _____ hr. _____ min

9. Birthplace Saline County, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business at home

12. Name Alexander Kelin

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

14. Maiden name Sorena Kirby

15. Birthplace No. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Eda Larcus

(b) Address 3663 French Ave

17. (a) burial (b) Date thereof 7/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Paul Cem

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) JUL 28 1940 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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 Paul A. Keith

Licensed Embalmer No. 3612

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, fact should be so stated above.