

1940 AUG 3 1540

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24783
Do not use this space.

1. PLACE OF DEATH 2
 (a) County Calloway Registration District No. 104
 (b) Township _____ Primary Registration District No. 3008 Registered No. 182
 (c) City Fullon (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Walter J. St. Cyr
 (a) Residence, No. State Hospital 701 St. St. Louis Mo 1512.588
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 2

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-1 1891

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>49</u>	<u>10</u>	<u>24</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Garage Operator

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

13. NAME Alfred St. Cyr

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

15. MAIDEN NAME Uncle

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Uncle

17. INFORMANT (ADDRESS) Alfred J. St. Cyr
2223 Oregonia Ave. St. Louis Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Louis Mo DATE July 29 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James A. Bull
4452 Washington Ave. St. Louis Mo

20. FILED 7/26 1940 R.N. Cross
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25th 1940

22. I HEREBY CERTIFY, That I attended deceased from March 7 1938 to July 25 1940
 I last saw him alive on July 25 1940 Death is said to have occurred on the date stated above, at 7:45 p.m.
 The principal cause of death and related causes of importance were as follows:
Dementia Paralytica
Chronic Hepatitis
 Date of onset 1937

Other contributory causes of importance: _____

Name of operation none Date of _____
 What test confirmed diagnosis? Cholesterol Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) John J. Blaska / M. D.
F. Patton / M. D.

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.

Social Security No - none

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.