

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26200**

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **1326**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Berkeley City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
9400 Natural Bridge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town Berkeley City
(If outside city or town limits, write "RURAL")
(d) Street No. 9400 Natural Bridge
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William H. Massey **201**

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased _____
(Month) (Day) (Year)
7 12 1865

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

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

10. Usual occupation _____

11. Industry or business Retired Farmer

12. Name George D. Massey

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

14. Maiden name Unknown - Ross

15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Minola Koenig

(b) Address 9400 Natural Bridge Road

17. (a) Burial (b) Date thereof 7-17-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Edith B. Archambault

(b) Address 4234 Mangrove

19. (a) JUL 16 1940 (b) R. M. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 15
year 1940 hour 3 minute 25 AM.

21. I hereby certify that I attended the deceased from June 22nd, 1940, to July 14th, 1940
that I last saw him alive on July 12th, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death gangrene of intestine and digestive organs in general.
Due to Distention and point of origin not known

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 46

Of autopsy _____

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 John A. Kouzelman (M. D. or other) 1/16/40

Address 6667 Delmar Date signed 7/16/40

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

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.

1 X1811

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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 *Florenz Eynck*
Licensed Embalmer No. *1284*
P. O. Address *St Louis Mo*

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.

Handwritten initials or mark at the bottom right.