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No. 2
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FILED SEP 25 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27397**
Registrar's No. **7293**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days
(Specify whether
In this community 30 yrs.
years, months or days)

3. (a) PRINT FULL NAME Louis Duxstad **233**
3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

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

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

7. Birth date of deceased April 2, 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 4 14 hr. min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name Unknown Louis BUXSTAD

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

14. Maiden name Unknown ANNA SIMPSON

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

16. (a) Informant Annie Morrison

(b) Address City Hospital, #1

17. (a) BURIAL (b) Date thereof 8-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OHVAARF

18. (a) Signature of funeral director Kullback & Kelly

(b) Address 1416 N. Taylor St.

19. (a) AUG 30 1940 (b) J.P. Kullback
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State 0 Missouri (b) County.....
(c) City or town St. Louis **11**
(If outside city or town limits, write "RURAL")
(d) Street No. Ozanam Shelter, 3225 Montgomery
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16,
year 1940 hour 4:30 minute P. A. M.

21. I hereby certify that I attended the deceased from August 14, 19 40 to August 16, 19 40
that I last saw him alive on August 16, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Purulent Meningitis Duration 3 days

Due to Purulent Pelvicitis 7

Due to.....
Other conditions Generalized Arteriosclerosis 0 yrs.
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: as above **890**
Of operations.....
Of autopsy.....
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) (c) Means of injury.....

23. Signature John J. Henry (M. D. or other) **1**
Address 1515 Lafayette Ave. Date signed 8/20/40

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

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 _____

_____ *Myself* _____, Registered Apprentice No. _____
working under my personal supervision.

*City of St. Louis
#145*

Signed *Glen E. Halerson*

Licensed Embalmer No. *4141*

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.