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1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

29633

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1537

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Lemay  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Mermac Bottoms Road. 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3703 So. Broadway  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Charles O. Addison 325  
 3. (b) If veteran, name war No.  
 3. (c) Social Security No. No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 11  
 year 1940 hour 12:30 minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from March 25, 1937  
 \_\_\_\_\_, 19\_\_\_\_ to Aug 11, 1940;  
 that I last saw him alive on Aug 7, 1940;  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Josephine 6. (c) Age of husband or wife if alive 54 years  
 7. Birth date of deceased Dec. 28, 1884  
(Month) (Day) (Year)

Immediate cause of death  
Ischemic Heart Disease  
Coronary Artery Disease

8. AGE: Years Months Days If less than one day  
55 7 14 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to 34  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Roofer

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business Unemployed  
 MOTHER FATHER {  
 12. Name Addison  
 13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Josephine Addison  
 (b) Address 3703 So. Broadway  
 17. (a) Burial (b) Date thereof 8-14-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation PARK LAWN CEM. Fendler Und Co.

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? \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address 7420 Michigan Ave  
 19. (a) AUG 13 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature Robert J. Farrell (M. D. or other) [Signature]  
 Address 1224 N. Union Date signed 8/10/40

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

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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.....

..... 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, fact should be so stated above.**