No. 2
1-10-39
17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29738

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1646

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Station Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (2) Two Days (Specify whether years, months or days)

In this community 12 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Jefferson Barracks, Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 9915 Lynn, St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? — — — years.

3. (a) PRINT FULL NAME William (None) Deremiah

3. (b) If veteran, name war Spanish America

3. (c) Social Security No. — — —

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife — — —

6. (c) Age of husband or wife if alive — — years

7. Birth date of deceased July (Month) 12 (Day) 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
73	1	16	— hr. — min.

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

10. Usual occupation Retired Soldier

11. Industry or business Unknown

FATHER 12. Name Unknown

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

MOTHER 14. Maiden name Unknown

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

16. (a) Informant Records, Station Hospital

(b) Address Jefferson Barracks, Mo.

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

(c) Place: burial or cremation NATIONAL CEMETERY

18. (a) Signature of funeral director C. Hoffmeister & Co.

(b) Address 7814 S. Broadway

19. (a) AUG 29 1940 (Date received local registrar) (b) R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28th year 1940 hour fifth minute ;05 A.M.

21. I hereby certify that I attended the deceased from August 25, 1940 to August 28, 1940 that I last saw him alive on August 28, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, chronic, and Myocardial degeneration.

Due to Arteriosclerosis, generalized.

Due to Chronic Otitis, Media

Other conditions Chronic Otitis, media (Include pregnancy within 3 months of death)

Major findings: Of operations 93 C

Of autopsy 1. Arteriosclerosis, generalized advance. 2. Congestive heart failure

Duration

PHYSICIAN — Underline the cause to which death would 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? — — — — — — — — — — — — (Specify type of place)

While at work? — — (e) Means of injury — — —

23. Signature Henry Sydow 1st. Lt. MCR (M. D. or other) Henry Sydow

Address Station Hosp., Jeff. Bks., Mo. Date signed 8-28/4

(Licensed Embalmer's Statement on Reverse Side)

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 Harry J. Schumac

Licensed Embalmer No. 2679

P. O. Address 732 Lemay

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.