

No. 2  
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17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30093**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7370**

1. PLACE OF DEATH

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution St. Louis City Hospital  
(d) Length of stay: In hospital or institution 3 (Specify whether years, months or days)

In this community 3 years, months or days

3. (a) PRINT FULL NAME Joseph Rodvick

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color 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 Unknown (Month) (Day) (Year)

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

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

10. Usual occupation None 9

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown 9

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

14. Maiden name "

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

16. (a) Informant Wm. Johnson - P.D.  
(b) Address 4459 Spruce

17. (a) \_\_\_\_\_ (b) Date thereof 12-48 (Month) (Day) (Year)  
(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. Rabin  
(b) Address 3500 Rutger

19. (a) SEP 3 1940 (b) J. Rodvick (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 3225 Montgomery (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 26  
year 1940 hour 7:40 minute 8 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Pyonephrosis  
Chronic Myocarditis  
Due to no stones  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: 930  
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)  
(e) Means of injury \$

23. Signature Joseph M. Green (M. D. or other)  
Address Deputy Date signed \_\_\_\_\_

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, above space should be left blank.**