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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. 30231

Registration District 791 Primary Registration District No. 1003 Registrar's No. 2568

1. PLACE OF DEATH:  
(a) County  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4448a Delmar  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No 2  
(Specify whether  
In this community All his life  
years, months or days)

3. (a) PRINT FULL NAME AMY J. JAMES

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

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

6. (b) Name of husband or wife Henry F. 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Dec 20 1864  
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 15 If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Hook, Loma

11. Industry or business

12. Name Caroline Hargood

13. Birthplace St. Charles Mo. (City, town, or county) (State or foreign country)

14. Maiden name Mary Hargood

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

16. (a) Informant Lillian Hargood (b) Address 4448a Delmar

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

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director A. W. M. Laughlin (b) Address 2301 Lafayette St. Louis Mo. (c) SEP 6 1940 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County  
(c) City or town ST. LOUIS 19  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4448a Delmar  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 5 th  
year 1940 hour 10:40 minute P. M.

21. I hereby certify that I attended the deceased from April 1940 to Sept 5, 1940  
that I last saw him alive on Sept 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral Hemorrhage 1 week  
Hypertension 1 week  
Due to  
Anterior Sclerosis

Other conditions  
(Include pregnancy within 3 months of death)  
Faulty union of left hip bone  
Hip fracture

Major findings:  
Of operations  
Of autopsy  
Physician  
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?

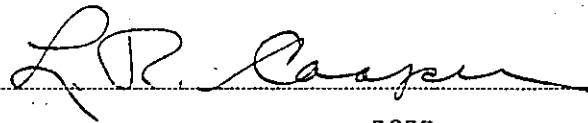
While at work? (Specify type of place) (e) Means of injury

23. Signature A. W. Krall (M. D. or other)  
Address 2704 Cass Date signed 9/6/40

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.....3633

P. O. Address 2317 Lafayette Ave.

**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.**