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WHITE 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. 33459

FILED NOV 16 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8156

1. PLACE OF DEATH:

(a) County St Louis

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

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

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State Mo (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL") 22

(d) Street No. 918 So 4th (If rural, give location)

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

3. (a) PRINT FULL NAME Charles HIGEE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

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	Months	Days	If less than one day
Unk 45	—	—	hr. min.

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

10. Usual occupation Unknown

11. Industry or business

FATHER

12. Name Unknown

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

MOTHER

14. Maiden name

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

16. (a) Informant Albert Koenig

(b) Address 5900 Ka

17. (a) Burial, cremation, or removal (b) Date thereof 9-3-40 (Month) (Day) (Year)

(c) Place burial or cremation

18. (a) Signature of undertaker

(b) Address 3500 Hulen

19. (a) (Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 14 year 1940 hour 12:27 minute P. M.

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

Immediate cause of death

Due to Lobar Pneumonia

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph M. Lucas (M. D. or other)

Address Deputy Coroner Date signed

(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 _____

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.