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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33628**
Registrar's No. **8325**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis Mo.**
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **4223rd Olive St**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **20 yrs**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **MAXIMINE G. DIVINAGRACIA**

3. (b) If veteran, name war **nil**
3. (c) Social Security No. **709-10-2209**

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

6. (b) Name of husband or wife **Clethra**
6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **may 29 1898**
(Month) (Day) (Year)

8. AGE: Years **42** Months **4** Days **6**
If less than one day hr. min.

9. Birthplace **Bacon, Mississippi**
(City, town, or county) (State or foreign country)

10. Usual occupation **Railman, Pullman**

11. Industry or business **alphonso**

12. Name **alphonso**

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

14. Maiden name **Winters**

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

16. (a) Informant **Mrs. Clethra Divinagracia**

(b) Address **4223rd Olive St**

17. (a) **Burial** (b) Date thereof **Oct 8 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lake Charles**

18. (a) Signature of funeral director **Wm. L. Bras**
(b) **OCT 7 1940**
(Date received local registrar) (Signature)

19. (a) **OCT 7 1940** (b) **John Bras**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4223rd Olive St**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **25** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **5**
year **1940** hour **8 15** minute **PM** M.

21. I hereby certify that I attended the deceased from **June 1** 1940 to **Oct 5** 1940

that I last saw ~~him~~ alive on **Oct 4** 1940 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction - from coronary artery disease**

Due to **metastases to liver**

Other conditions **1 yr ago at St. Louis - 11 years ago**

Major findings: Of operations **1 yr ago at St. Louis - 11 years ago**

Of autopsy **1 yr ago at St. Louis - 11 years ago**

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 **Eugene J. Quadey** (M. D. or other)

Address **St. Louis** Date signed **10-5-40**

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

Howard H. Powell

Licensed Embalmer No.

3114

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.