

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34142**
Registrar's No. **8839**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town. **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Days** (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Arthur Joslin**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Elizabeth Joslin** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **Aug. 25, 1883**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 **2** **0** hr. min.

9. Birthplace **Detroit, Michigan**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cabinet Maker**

11. Industry or business.....

MOTHER FATHER { 12. Name **Charles Joslin** !
13. Birthplace **Detroit, Michigan**
(City, town, or county) (State or foreign country)
14. Maiden name **Louisa Coty**
15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth Joslin**
(b) Address **5841 Cote Brilliant**

17. (a) **Burial** (b) Date thereof **10-28-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Walhalla Cem.**

18. (a) Signature of funeral director **Jay B. Smith**
(b) Address **7456 Manchester**

19. (a) **Oct 27 1940** (b) *J. B. Smith*
(Date of death) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis** **25**
(If outside city or town limits, write "RURAL")
(d) Street No. **1529 Franklin**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **25**,
year **1940** hour **7:20** minute **P.** M.

21. I hereby certify that I attended the deceased from **October 22**, 19 **40**, to **October 25**, 19 **40**
that I last saw him alive on **October 25**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death
Greenia Pulmonary tuberculosis

Due to.....
Due to.....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy **No**

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) (c) Means of injury **1**

23. Signature *John J. Henry* (M. D. or other)
Address **1515 Lafayette Avenue** Date signed **10/26/40**

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.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.