

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36328**

Registration District No. **784** Primary Registration District No. **200** Registrar's No. **2037**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(b) City or town **KACH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ROBERT KOCH HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **97 days**
(Specify whether years, months or days) **8 years**

3. (a) PRINT FULL NAME **ERNEST DANIELS**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **2**

4. Sex **M** 5. Color or race **N** 6. (a) Single, widowed, married, divorced **SEPARA**

6. (b) Name of husband or wife **ADIE MATON** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **OCTOBER 27 1913**
(Month) (Day) (Year)

8. AGE: Years **27** Months **0** Days **2** If less than one day hr. _____ min. _____

9. Birthplace: **GEORGIA**
(City, town, or county) (State or foreign country)

10. Usual occupation **TRUCK DRIVER**

11. Industry or business

MOTHER FATHER { 12. Name **EDDIE DANIELS**
13. Birthplace **GEORGIA**
(City, town, or county) (State or foreign country)
14. Maiden name **METZIE COATS**
15. Birthplace **GEORGIA**
(City, town, or county) (State or foreign country)

16. (a) Informant **KACH RECORDS**

(b) Address **813 S. 8th St.**

17. (a) ☒ (Burial, cremation, or removal) (b) Date thereof **30 30 1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **A. J. Burke**

(b) Address **1619 S. 8th St.**

19. (a) **OCT 30 1940** (b) **R. Meyer**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS**
(If outside city or town limit, write "RURAL")
(d) Street No. **811 S. 9th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER** day **29**
year **1940** hour **10** minute **05 A.**

21. I hereby certify that I attended the deceased from **JULY 24 1940** to **OCTOBER 19 1940**
that I last saw him alive on **OCTOBER 29, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **CHRONIC PULMONARY**
Due to **TUBERCULOSIS**

Due to **72**

Other conditions **(Include pregnancy within 3 months of death)**

Major findings: Of operations _____

Of autopsy _____

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 **James H. [illegible]** (M. D. or other) **1**
Address **Kach [illegible]** Date signed **10/30/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Louis V. Atkins

Licensed Embalmer No.

2842

P. O. Address

3644 Finney

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.