

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39802**
Registrar's No. **2157**

Registration District No. **784**

Primary Registration District No. **1993**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Richmond Heights**
(c) Name of hospital or institution: **St. Marys Hospital Richmond Heights**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 days**
(Specify whether
In this community
years, months or days)

3. (a) PRINT
FULL NAME

ERNEST McGuire (Geier)

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex **M** Color or
race **W**

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive years

7. Birth date of deceased **June 24 1936**
(Month) (Day) (Year)

8. AGE: Years **4** Months **4** Days **7**

If less than one day
hr. min.

9. Birthplace **St. Louis**
(City, town, or county)

Mo
(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Charles Geier (M. J. father)**

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

14. Maiden name **Edna M. Geier**

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

16. (a) Informant **Charles Geier**

(b) Address **1713 Oregon Ave**

17. (a) **Removal** (b) Date thereof **11-8-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cemetery Potosi**

18. (a) Signature of funeral director **Sparks**

(b) Address **NOV 8 1940**

19. (a) (Date received local registrar) (b) **70 Potosi Mo**
(Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St. Louis**
(c) City or town **23**
(If outside city or town limits, write "RURAL")
(d) Street No. **1713 Oregon**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT** day **28**
year **1940** hour **12:** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **10**
19 **1940** to **10/28** **1940**
that I last saw him alive on **10/19/40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **1 hr.**

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy **Splitting of cerebellum and
a recent cerebellar hemorrhage**

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

Signature **Mark H. Donora** (M. D. or other) **MD**

Address **St. Marys Hosp.** Date signed **10/28/40**

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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.