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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

JUN 11 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18902

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 83

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution:  
State Hospital No. 4  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME EARL JANSSEN

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Velma Dunbar Age of husband or wife if alive Unknown years

7. Birth date of deceased July 15 1907  
(Month) (Day) (Year)

8. AGE: Years 33 Months 9 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Coal dealer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Janssen

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

14. Maiden name Sarah Trueman

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

16. (a) Informant State Hospital No. 4 Records

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 5-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis County

18. (a) Signature of funeral director James F. Smith

(b) Address St. Louis, Mo.

19. (a) May 21-41 (b) P. J. Robinson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis City

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

(d) Street No. 6743 Hoffman  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st  
year 1941 hour 9 minute 10 A.M.

21. I hereby certify that I attended the deceased from May 1st, 1941 to May 21st, 1941,  
that I last saw him alive on 5-21-41, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death Syphilis of central nervous system with psychosis (Paresis) (Terminal cerebral hemorrhage)  
Therapeutic malaria

Duration  
2/19/41  
2 hrs.

Due to \_\_\_\_\_

Other conditions NONE  
(Include pregnancy within 3 months of death)

Major findings: NO  
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) NO

(b) Date of occurrence NO

(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?

23. Signature G. Ivis Graves, Jr. (Specify type of place) (a) Means of injury \_\_\_\_\_  
Address Farmington, Mo. (M. D. or Other) M.D.  
Date signed 5/21/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 21 1954

**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 James Higgins  
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.**