No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 8 1941

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 26305

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1614

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

**1. PLACE OF DEATH:**

(a) County St. LOUIS

(b) City or town KOCH (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 18 days (Specify whether

In this community 27 years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis 96

(c) City or town St. Louis 0 (If outside city or town limits, write "RURAL")

(d) Street No. 1909 DIVISION 0 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME THEODORE LASSITER

3. (b) If veteran, name war

3. (c) Social Security No. 498-03-8988

4. Sex male 2

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced separ. 1

6. (b) Name of husband or wife NEVADA JOHNSON

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

7. Birth date of deceased September (Month) 4. (Day) 1905 (Year)

8. AGE: Years 35 Months 10 Days 25 If less than one day hr. min.

9. Birthplace WILSON (City, town, or county) / ARK. (State or foreign country)

10. Usual occupation LABORER

11. Industry or business WPA

FATHER
12. Name ALLEN LASSITER
13. Birthplace unknown (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name WILLIE GERMAN
15. Birthplace TREUMAN (City, town, or county) / TENN. (State or foreign country)

16. (a) Informant Hospital Record

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof 8-2-41 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director [signature]

(b) Address 9774 Chadwick

19. (a) AUG 2 - 1941 (Date received local registrar) (b) [signature] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month ~~Sep~~ July day 29 year 1941 hour 2 minute 20 A. M.

21. I hereby certify that I attended the deceased from July 11, 1941, to July 29, 1941, that I last saw him alive on July 28, 1941 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary hemorrhage | |
| Due to Pulmonary tuberculosis | ? |
| Due to | |
| Other conditions Syphilis (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Franz U. Steinberg (M. D. or other) M-D

Address Robert Koch Hospital Date signed 7-29-41

(Licensed Embalmer's Statement on Reverse Side)

## 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 Thos. L. Howell

Licensed Embalmer No. 2452

P. O. Address 3028 Dicks

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

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