

No. 2
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17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **33482**
Registrar's No. **8438**

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 **D**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME John McBee

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Feb. 28 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 7 25 ..hr.min.

9. Birthplace Mine La Motte Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business.....

12. Name John McBee

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

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Fern Lembaugh

(b) Address 4165 Lafayette Ave.

17. (a) Burial (b) Date thereof 10/26/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT 24 1941 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4165 Lafayette Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?.....years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23,
year 1941 hour 3:40 minute P.M.

21. I hereby certify that I attended the deceased from October 14, 19 41 to October 23, 19 41
that I last saw him alive on October 23, 19 41
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio sclerosis
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy No autopsy

Duration
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) (i) Means of injury
23. Signature M. M. Kurl (M. D. or other)
Address 1515 Lafayette Avenue, St. Louis

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

MOTHER FATHER

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

J. W. Binkley

Licensed Embalmer No.

3653

P. O. Address

St. Louis, Mo

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, fact should be so stated above.