

S. No. 2
-1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Co 000
State File No. 35997
Registrar's No. 2177

Registration District No. 1844

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St Louis County Hospt
(b) City or town St Louis County Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis County Hospt
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
(c) City or town St Louis 2 City
(If outside city or town limits, write "RURAL")
(d) Street No. 6723 Chamberlaine
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Oscar E Life
3. (b) If veteran, name war No
3. (c) Social Security No. 493-05-348

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25
year 1941 hour 1 minute A M.
21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lorene 6. (c) Age of husband or wife if alive 46 years

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death Collision of car he was driving with another car on a public highway. Duration _____

7. Birth date of deceased Jan 17 1891
(Month) (Day) (Year)
8. AGE: Years 50 Months 9 Days 8 If less than one day
hr. _____ min. _____

Due to Fracture of skull; subarachnoid hemorrhage; fractured ribs;
Due to Bilateral hemothorax.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings _____

11. Industry or business Union Electric
12. Name James M Life
13. Birthplace Unk (City, town, or county) (State or foreign country)
14. Maiden name Maria O'Leary
15. Birthplace Unk (City, town, or county) (State or foreign country)

Of operations _____
Of autopsy Yes.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant L/rene Life
(b) Address 6723 Chamberlaine
17. (a) _____ (b) Date thereof 10-28-41
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Oct. 25, 1941
(c) Where did injury occur? Page Av. W. of Ferguson
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place

(c) Place: burial or cremation Valhalla
18. (a) Signature of funeral director Alexander
(b) Address 6175 - 2nd St
19. (a) OCT 25 1941 (Date received local registrar) (b) C. H. McFarren (Registrar's signature)

While at work? _____ (e) Means of injury Car
23. Signature Louis A. Bopp (Date of death)
Address Kirkwood, Mo. 10/25/41 Date signed

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

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, fact should be so stated above.