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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 1 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39499  
Registrar's No. 2365

Registration District No. 784  
Primary Registration District No. 200

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Overland  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2477 Ashland  
(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 Missouri (b) County St. Louis  
(c) City or town Overland  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2477 Ashland  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lawrence Samuels  
3. (b) If veteran, name war No.  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mt. Vernon Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Ice Plant

MOTHER FATHER { 12. Name Lee Samuels  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Francis Lamb  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bernice Hughes  
(b) Address Overland, Mo.

17. (a) Removal (b) Date thereof 11-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Vernon, Mo.

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

(b) Address 4700 Washington Ave.

19. (a) NOV 24 1941 (b) H. M. Neuman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11/22/41 day \_\_\_\_\_  
year \_\_\_\_\_ hour 11:30pm minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 9/4/41 19\_\_\_\_;  
\_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on 11/22/41 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion - old & cerebral infarct (recent)  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Off a  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature Arthur P. Barrow (M. D. or other) \_\_\_\_\_  
Address 8600 N. Bridge Date signed 11/22/41

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

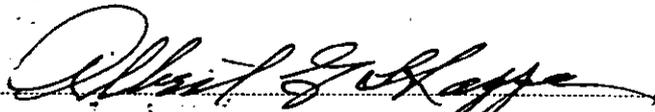
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**STATEMENT BY LICENSED EMBALMER**

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..... 2971

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.**

Information missing on Cert.  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 784Primary Registration District No. 200Registrar's No. 2365

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Overland  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2477 Ashland  
(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)

3. (a) PRINT FULL NAME Lawrence Samuels3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 495-07-2690

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Feb. 8 1885  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
56 9 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)10. Usual occupation Laborer11. Industry or business Ice Plant

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-2-1947 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
 (c) City or town Overland  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2477 Ashland  
(If rural, give location)  
 (e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH, Month \_\_\_\_\_ day \_\_\_\_\_  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

S-39499