

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 475

FILED FEB 24 1942 911  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Residence-5959 Clements  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 5  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5959 Clements  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

3. (a) PRINT FULL NAME BRAINARD M. Godfrey

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

4. Sex M D 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased MAR 11 1873  
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 4 If less than one day hr. min.

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

10. Usual occupation ATTORNEY

11. Industry or business Federal Traffic Bureau

12. Name WM Godfrey

13. Birthplace IRCHAND 4  
(City, town, or county) (State or foreign country)

14. Maiden name ALICE MILLION

15. Birthplace KY 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. D. Barnes

(b) Address 5959 Clements

17. (a) Burial (b) Date thereof 1/17/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem

18. (a) Signature of funeral director Alexander Sons

(b) Address 6170 Deligan

19. (a) JAN 20 1942 (Date received local registrar) J. P. Prestek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 1942 hour 8 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct 12 1941 to 1-15 1942 and that death occurred on the date and hour stated above.

that I last saw him alive on 1/15 1942  
Immediate cause of death leukemia  
Coelution

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

23. Signature W. H. D. [unclear] (M. D. or other) \_\_\_\_\_

Address 4500 Olive St Date signed 1/17/42

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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.....

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.

*Cert to be embalmed*