

S. No. 2
M-9-4-41
Rev. 5-17-39
X 29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4319

FILED MAR 17 1942 791

Registration District No. Primary Registration District No. 1003 Registrar's No. 1829

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution City Hosp # 1
(d) Length of stay: In-hospital or institution _____
In this community: _____
years, months or days

3. (a) PRINT FULL NAME Charles Felts
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 1860
(Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation sub

11. Industry or business Unknown

12. Name Unknown 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant James T. Johnson
(b) Address 1300 Clark

17. (a) _____ (b) Date thereof 2-26-42
(Month) (Day) (Year)

18. (a) Signature of funeral director W. P. Kelly
(b) Address 3500 Fitzg

19. (a) FEB 27 1942 (b) J. C. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 21500
(c) City or town St. Louis 17
(d) Street No. 125 No 6 St 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 16
year 1942 hour 1 minute 55 P.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
Due to _____
Due to _____
Other conditions 82
(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) _____
(a) Means of injury 3
23. Signature Alfred Terry (M. D. or other) _____
Address _____ Date signed 2/25/42

(Licensed Embalmer's Statement on Reverse Side)

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

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MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.