

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 9 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4972**

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5844 West Florissant /
(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.....
(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5844 West Florissant**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Henry P. Mahr**

3. (b) If veteran, name war..... 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **June 5, 1856**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 11 22 ..hr. ..min.

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Stonemason (retired)**

11. Industry or business.....

MOTHER FATHER { 12. Name **Peter Mahr**
13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Bernard**
15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address **8554 Mora Lane**

17. (a) **Burial** (b) Date thereof **May 31, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Bromschwig Und. Co.**
(b) Address **4746 West Florissant**

19. (a) **MAY 29 1943** (b) **J. F. Breda**
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27**
year **1943** hour **9.15 P.** minute..... M.

21. I hereby certify that I attended the deceased from **May 30th** 19 **42** to **May 27** 19 **43**
that I last saw him alive on **May 27th** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Chronic Myocarditis** Duration **2 yrs**

Due to..... **Chronic Prostatitis** **5 Yrs**

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 **Edwin J. Grobil** (M. D. or other) **M.D.**
Address **3635 No. Newstead** Date signed **5/28/43**

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.....

W. Wilkin

Licensed Embalmer No.....

3575

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.