

S. No. 2
DOM-2-43
5-17-39
X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **29946**
Registrar's No. **8259**

FILED SEP 28 1943
Registration District No. **238**

Primary Registration District No. _____

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:
8723 Riverview Blvd.
(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 000
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 8723 Riverview Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CARL GAFFRON

3. (b) If veteran, name war _____ 3. (c) Social Security No. 494-10-8927

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frieda Gaffron 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased June 30th 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 2 15 _____ hr. _____ min.

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

10. Usual occupation Machinist

11. Industry or business Johanson Bros Shoe Co

12. Name Bodo Gaffron

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

14. Maiden name Unknown

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

16. (a) Informant Frieda Gaffron

(b) Address 8723 Riverview Blvd.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/18/43 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Calvin F. Feuty

(b) Address 4828 Nat Bridge Blvd

19. (a) SEP 17 1943 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 15th
year 1943 between 8:00 & 11:00 P. M.
hour minute

21. I hereby certify that I attended the deceased from February 4th 1939 to July 14th 1943
that I last saw him alive on July 14th 1943
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Embolism Duration _____

Due to Multiple Diverticulums of Transverse & descending 5 years
Due to hemorrhage - Colon
from Colon - last Sept 10th 1943

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

Major findings: Of operations W

Of autopsy _____

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) Means of injury _____
23. Signature Chas. H. Wernsberg (M. D. or other) 11/19
Address 3232 Lafayette Date signed 11/19/43

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.....
John A. Mlinar

Licensed Embalmer No.....*4186*

P. O. Address.....*St. Louis Mo*

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.

Registration District No. 318 Primary Registration District No. 1003

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Carl Staffron
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased June 30 1891
(Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

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)..... (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) DEC 6 1943 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept year 1943 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 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) (c) Means of injury.....
23. Signature..... (M. D. or other).....
Address..... Date signed.....

W-2181
SUPPLEMENTARY

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

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

