

S. No. 2
DM-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30154

State File No.

Registrar's No.

8329

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:
City Hospital
(If not in hospital or institution, write street number or location) 0
(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. 2225a S. 2nd St.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Charles Livingston

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 Married

6. (b) Name of husband or wife Nellei Livingston 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased April 8, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 5 9 hr. min.

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

10. Usual occupation Switchman

11. Industry or business Car Shop

12. Name Robert Livingston

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

14. Maiden name Don't Know

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Livingston

(b) Address 2225a S. 2nd St.

17. (a) Burial (b) Date thereof Sept. 20, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter and Paul Ch.

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

(b) 2201 S. Grand Bl.

19. (a) SEP 20 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17
year 1943 hour 1 minute 30 P.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 Cerebral Hemorrhage
Due to.....

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
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.....
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 [Signature] (M. D. or other)
Address [Signature] Date signed 9/20/43

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

MOTHER FATHER

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.....

Henry A. Stewart

Licensed Embalmer No..... **3722**.....

P. O. Address..... **412 Duchouquette St.**.....

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.