

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

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30498**
Registrar's No. **8607**

FILED OCT 13 1943

Registration District No. _____

Primary Registration District No. _____

1000

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital #1.
(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. **1123 South 8th Street.,**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Calvin Voyles**

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

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

6. (b) Name of husband or wife **Lulu Voyles** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **September 6 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 0 23 hr. min.

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

10. Usual occupation **Painter**

11. Industry or business

12. Name **Albert Voyles**
13. Birthplace **Staunton Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Nash**
15. Birthplace **Shannon County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lulu Voyles**
(b) Address **1123 South 8th Street.,**

17. (a) **Burial** (b) Date thereof **9/30/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bonne Terre, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**
(b) Address **4700 Washington Blvd.,**

19. (a) **SEP 20 1943** **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **29**
year **1943** hour **7** minute **45** 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 _____
Brain Tumor

Due to **Benign**

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)
23. Signature **Dr. Albert H. Hoppe** (M.D. or other)
Address **Physician's Office** Date signed **9/30/43**

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

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

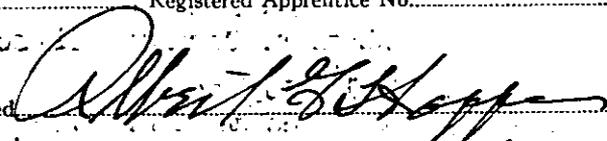
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

working under my personal supervision.

Registered Apprentice No.....

Signed .....

Licensed Embalmer No. 2971.....

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.