

S. No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4255**

FILED JAN 24 1944
Registration District No. **2**

Primary Registration District No. **6076**

Registrar's No. **114**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Kosh.
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 133 days
In this community 133 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4054 - N. Broadway
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME HARRY ANDREWS - DENNIS

3. (b) If veteran, name war no 3. (c) Social Security No. yes

4. Sex male 5. Color or race white
6. (a) Single, widowed, married
divorced M.
6. (b) Name of husband or wife Ella Lube Dennis 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased June 25 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 70 5 20 hr. min.

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

10. Usual occupation Street Car Maloman

11. Industry or business

MOTHER FATHER { 12. Name HARRY DENNIS
13. Birthplace Penn.
(City, town, or county) (State or foreign country)
14. Maiden name SARAH FREE
15. Birthplace Penn.
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Robert
(b) Address Kosh. Hospital

17. (a) Burial (b) Date thereof 1-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2823 St. Louis Ave.

19. (a) JAN 17 1944 (b) E. J. McLawrence
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 th.
year 1944 hour 6:00 AM minute 00 M.
21. I hereby certify that I attended the deceased from August 31, 1943, to 1-14, 1944
that I last saw him alive on 1-13, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis bilateral
Duration 24 mos. 9

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

Major findings:
Of operations
Of autopsy none - 1st

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 Frank M. Timberly (M. D. or other)
Address Robert Koch Hospital Date signed 1-14-44

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 Homer L. Ponder

Licensed Embalmer No. 30367

P. O. Address 223 St. Louis ave

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.