

FILED MAR 6 1944

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STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5069

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1970

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Washington
(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

3. (a) PRINT FULL NAME

NOAH ELKINS

3. (b) If veteran, name war

None

3. (c) Social Security No.

None

4. Sex Male 5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jane Elkins

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April 2 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 10 24 hr. min.

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

10. Usual occupation Retired

11. Industry or business

12. Name Peter Elkins

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

14. Maiden name Unknown

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

16. (a) Informant Robert Elkins

(b) Address Washington, Missouri

17. (a) Burial (b) Date thereof 2-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) FEB 28 1944 (b) J. P. Breda
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 26 year 44
hour 9 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 1-20-44
19, to 2-26-44, 19

that I last saw him alive on 2-26-44, 19
and that death occurred on the date and hour stated above.

Immediate cause of death

Cancer of prostate

Due to Arteriosclerosis

Due to Generalized

Other conditions Cystitis
(Include pregnancy within 6 months of death)

Major findings:
Of operations

Of autopsy

Duration

3 yrs.

3 yrs.

3 mos.

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) (e) Means of injury

23. Signature J. P. Breda (M. D. or other)

Address 4700 Washington Blvd. Date signed 2/26/44

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 *John Agnoski*
Licensed Embalmer No. *3398*
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.