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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1944

Registration District No. 318

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 16455

Registrar's No. 5051

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: St Johns Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

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. 4452 Washington Bl. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John V. Inman

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary Inman

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July (Month) 21 (Day) 1876 (Year)

8. AGE: Years 68 Months 3 Days 10 If less than one day hr. min.

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

10. Usual occupation City Inspector

11. Industry or business Street Dept.

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Anna Ashlock

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

16. (a) Informant Mary Inman

(b) Address 5844 Maple Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Chas. A. Bull

(b) Address 4452 Washington Blvd

19. (a) JUN 2 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 31 year 44 hour 2 minute 00 P.M.

21. I hereby certify that I attended the deceased from 1942, 19, to 5/31/44, 19; that I last saw him alive on 5/31/44, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	5 days
Due to: Vascular sclerosis	
Due to: ?	
Other conditions (Include pregnancy within 3 months of death): Congestive Lung, pneumonia	2 days

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

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. Krowmeller (M. D. or other)

Address 405 S Hunt Way Date signed 6/1/44

(Licensed Embalmer's Statement on Reverse Side)

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 Ketter

Licensed Embalmer No. 2880

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
4-25-41
X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 5051

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town _____ (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Johns Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) In this community _____

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 _____

3. (a) PRINT FULL NAME John V. Inman

3. (b) If veteran, name war _____

3. (c) Social Security No. 499-01-2642

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb (Month) 21 (Day) 1876 (Year)

8. AGE: Years 68 Months 3 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) JUN 12 1944 (Date received local registrar) (b) J. F. Bulleck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 31 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
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 _____

(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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

16455