

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22605

FILED JUL 8 1944

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1428

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
10592 Hobday
(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) 20 yrs

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis 9.6

(c) City or town Overland 1.3
(If outside city or town limits, write "RURAL")

(d) Street No. 10592 Hobday 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Joseph F Velton

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

4. Sex M 0 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

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

7. Birth date of deceased Oct 27 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>8</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation retired mailman carrier

11. Industry or business _____

12. Name Michael Velton

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

14. Maiden name Catherine Miller

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

16. (a) Informant Frank J. Velton

(b) Address St Louis Mo

17. (a) Burial (b) Date thereof 7/3/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Overland Mo

19. (a) JUL 3 1944 (b) E. B. McKeavran MD
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1944 hour _____ minute 6:15PM

21. I hereby certify that I attended the deceased from June 30th 1944 to June 30th 1944
that I last saw him alive on June 29th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 3 days
Due to arteriosclerosis 2 yrs.

Due to _____
Other conditions 8301
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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 H. J. Coleman M.D. (M. D. or other) _____
Address Pattonville Mo Date signed June 30, 44

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Al C. Ortman

Licensed Embalmer No. 3478

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.