

S. No. 2
OM-543
Rev. 5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

32660

State File No.

8941

FILED NOV 1 1944
Registration District No. 818

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(e) 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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 days (Specify whether Life)
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") 2217
(d) Street No. 2620a Market (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Oil

3. (b) If veteran, name war none 3. (c) Social Security No. unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
about 65 Unknown hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation labor

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant W. Hayens
(b) Address 2610 a Market St.

17. (a) Burial (b) Date thereof 10/23/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 8815 Franklin Ave

19. (a) OCT 21 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15,
year 1944 hour 1 minute 15 A. M.
21. I hereby certify that I attended the deceased from September
19, 1944 to October 15, 1944.
that I last saw him alive on October 15, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Benign Hypertrophy of Prostate Duration Unk.

Due to _____
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)
(c) Means of injury _____

23. Signature W. B. Christian (M. D. or other) [Signature]
Address 2601 N. White Date signed 10/27/44

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

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.....

Licensed Embalmer No. 2498

P. O. Address. 2749 Chouteau

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.