

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **120**
 Registrar's No. **418**

FILED JAN 25 1945
 Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Enroute to City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3**
(Specify whether years, months or days)

In this community **3**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
17

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **1221a Franklin**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Walter S. Cairl**

3. (b) If veteran, name war **Nil**

3. (c) Social Security No. **306-10-3208**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **11**
 year **1945** hour **1:00** minute **12** **ap.** M.

4. Sex **Male** 5. Color or race **White**

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

6. (c) Age of husband or wife if alive **38** years

7. Birth date of deceased **December 26 1887**
(Month) (Day) (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	57	0	15	_____ hr. _____ min.

Immediate cause of death **Chronic Coronary Heart Disease**
Chronic Hypertrophic Myocarditis

Due to _____

Due to _____

Other conditions **93**
(Include pregnancy within 3 months of death)

9. Birthplace **Unknown Michigan**
(City, town, or county) (State or foreign country)

10. Usual occupation **Iron Molder**

PHYSICIAN

Major findings:
 Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

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? _____

16. (a) Informant **Mrs. Ethel Cairl**

(b) Address **1221a Franklin Ave.**

17. (a) Burial (b) Date thereof **1-15-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

23. Signature **Albert H. Hoppe** (M: D: or other) **3**
While at work? (Specify type of place) (c) Means of injury

Address **4700 Washington Blvd.** Date signed **1/15/45**

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

(b) Address **4700 Washington Blvd.**

19. (a) Jan 15 1945 (b) **J. F. Brudick**
(Date received local burial) (Registrar's signature)

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.....

R. W. Wilkinson

Licensed Embalmer No..... *3575*

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.