

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 3 1945
318

Registration District No.

1003

Registrar's No.

1527

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3920a Gustine,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 1 year
years, months or days

3. (a) PRINT FULL NAME Eliga H. Townlan

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

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

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

7. Birth date of deceased January 10, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 1 4 hr. _____ min.

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

10. Usual occupation Fireman,

11. Industry or business _____

12. Name Unknown

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

14. Maiden name do

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

16. (a) Informant James Tracy,

(b) Address 3920a Gustine,

17. (a) Burial (b) Date thereof 2/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shiloh Cemetery Springfield Mo

18. (a) Signature of funeral director Oscar J Hoffmeister (Specify type of place) While at work? (c) Means of injury _____

(b) Address 4016 Chippewa,

19. (a) FEB 15 1945 J. F. Oredock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 3920a Gustine, (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1945 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb. 10
1945 to Feb. 14 1945
that I last saw him alive on Feb. 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Carcinoma stomach.

Due to _____

Due to _____

Other conditions Semility.
(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? _____

23. Signature J. R. Sheridan (M. D. or other) _____

Address 2602 So. Grand Date signed 2-15-45

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

MOTHER FATHER

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

Albert G. Koppa

.....
Licensed Embalmer No.

2971

.....
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.