

#16249

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11529

State File No. _____

FILED APR 23 1945
818

Primary Registration District No. 1003

Registrar's No. 31728

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

1. PLACE OF DEATH:

(a) 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:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 days
(Specify whether years, months or days)

In this community 18 years

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. 1022 Lynch
(If rural, give location)

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

3. (a) PRINT FULL NAME John Massie

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Minnie nee Adkins 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased January 24 1899
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>2</u>	<u>16</u>	hr. min.

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

10. Usual occupation Landscaper

11. Industry or business _____

MOTHER FATHER

12. Name John Massie

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Minnie Massie
(b) Address R 8 Box 651 Lemay Mo

17. (a) Burial (b) Date thereof Apr 11 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Trin Luth Cem

18. (a) Signature of funeral director Beiderwieden F H Inc
(b) Address 1936 St Louis Ave

19. (a) APR 10 1945 J. F. Budeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th
year 1945 hour 5:40 minute A. M.

21. I hereby certify that I attended the deceased from 3/13/45 to 4/9/45
that I last saw him alive on 4/9/45
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Urinary Bladder with metastases to the retroperitoneal lymphatics

Due to _____

Due to 52

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? _____

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature Edna S. Lipsit (M. D. or other) _____
Address 1515 Lafayette 4/9/45 signed _____

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..... *Glen W. Hat*
Licensed Embalmer No..... *3737*
P. O. Address..... *1936 St. Louis Ave*

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.