

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 30 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003 Registrar's No. 6711

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: City Hospital  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 31 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
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. St. Francis Hotel 6th & Chestnut  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 25  
0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BEN CHRISMER  
W. P. HENNY

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 489-05-5223

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28  
year 1945 hour 4:10 minute A M.

4. Sex M 5. Color of race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Pearl

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
5 (Day) 1888 (Year)

7. Birth date of deceased: Apr (Month) 5 (Day) 1888 (Year)

21. I hereby certify that I attended the deceased from June 27, 1945 to July 28, 1945;  
that I last saw him alive on July 28, 1945  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>3</u>	<u>23</u>	hr. _____ min. _____

Immediate cause of death. Pulmonary T.B. Duration \_\_\_\_\_

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

10. Usual occupation laborer

11. Industry or business air-transportation

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

MOTHER FATHER

12. Name Newton Chrismer

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

14. Maiden name Alice Davis

15. Birthplace Mo.  
(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 Claude Chrismer

(b) Address 3220 Eton Jennings, Mo.

17. (a) Calvary Cem (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

23. Signature Herbert C. Fitz (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Avenue Date signed 7/28/45

18. (a) Signature of funeral director J. F. Church  
(Specify type of pinure)

(b) Address 4911 Washington

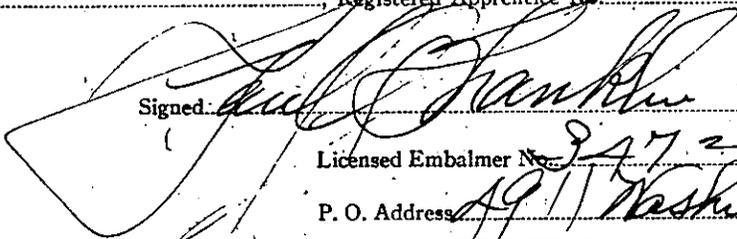
19. (a) JUL 30 1945 (b) J. F. Church  
(Date received local registrar) (Registrar's signature)

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:  .....

Licensed Embalmer No. 3472 .....

P. O. Address 4911 Washington .....

**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.**