

871
S. No. 2
OM-2-43
v. 5-17-39
W-I X3587

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED JUL 28 1945 STANDARD CERTIFICATE OF DEATH

State File No. 22002

Registration District No. 318 - Primary Registration District No. 1003

Registrar's No. 6254

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: 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 7 days (Specify whether
In this community 55 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 305 Lucas Avenue 9 2st
(If rural, give location)

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

3. (a) PRINT FULL NAME JOSEPH HANDS

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

4. Sex M O 5. Color or race W 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1945 hour 2:25 minute _____ P. M.

21. I hereby certify that I attended the deceased from July
11, 1945 to July 18, 1945
that I last saw him alive on July 18, 1945
and that death occurred on the date and hour stated above.

8. AGE: abt 73 Years Months Days If less than one day
hr. min.

Immediate cause of death
Pulmonary Artery Embolus

Due to Septic Venous Thrombosis

Due to Hb

Other conditions Carcinoma of Cecum
(Include pregnancy within 3 months of death)

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

10. Usual occupation Laborer

11. Industry or business unemployed

MOTHER FATHER { 12. Name Unknown

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

{ 14. Maiden name Unknown

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

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy see above

Underline the cause to which death should be charged statistically.

16. (a) Informant Raymond C. Hands
(b) Address 3526A Magnolia Ave., St. Louis, Mo

17. (a) Removal (b) Date thereof 7/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Independence, Mo.

18. (a) Signature of funeral director A. M. McLaughlin
(b) Address 2301 Lafayette Ave., St. Louis, Mo.

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

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?
(Specify type of place) _____

While at work? (c) Means of injury _____

23. Signature J. A. Stanton (M. D. or other) Med. Dir. Pitt.
Address 1215 Lafayette Avenue Date signed 7/18/45

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 *L. R. Cooper*

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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.