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#39014

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25820

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7537

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

(d) Length of stay: In hospital or institution 2mos-8days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36

(c) City or town Sullivan 4
(If outside city or town limits, write "RURAL")

(d) Street No. NR
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME LOUIS JOST

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Eva Jost

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

7. Birth date of deceased February (Month) 21 (Day) 1893 (Year)

8. AGE: Years 52 ~~25~~ Months 6 Days 8 If less than one day hr. min.

9. Birthplace Sullivan (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Peter Jost
13. Birthplace Union (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Annie Halmich
15. Birthplace Sullivan (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant George Jost
(b) Address Owensville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Sullivan, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 31 1945 (Date received local registrar) (b) J. F. Brideck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28th
year 1945 hour 12:01 minute am M.

21. I hereby certify that I attended the deceased from 6/21/45, 19, to 8/28/45, 19;
that ~~I last~~ saw him alive on 8/28/45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Multiple lung abscesses

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 114d

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

23. Signature Alice Thomas (M. D. or other)
Address 1515 Lafayette Date signed 8/28/45

(Licensed Embalmer's Statement on Reverse Side)

SEP 18 1945

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 John W Ogonoski

Licensed Embalmer No. 3398

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.