

S. No. 2
OM-5-43
v. 5-17-39
I X36671

#46132
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 29111

FILED 00318 1945

Registration District No. Primary Registration District No. Registrar's No. 8386

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 5 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000.
(c) City or town St. Louis
(If outside city or town limits, write "RURAL.")
(d) Street No. 1618 No. 14th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME JOHN WM. HUMPHREY
3. (b) If veteran, name war Unk. 3. (c) Social Security No. Unk.

4. Sex male 0 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 5th, ??
(Month) (Day) (Year)

8. AGE: Years abt - 74 Months Days If less than one day
hr. min.

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

10. Usual occupation Unk

11. Industry or business.

12. Name Frank Humphrey

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

14. Maiden name Lisheth Unk

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

16. (a) Informant M. Renard

(b) Address Anatomical Board

17. (a) Date thereof 9-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director J. F. Bredbeck

(b) Address 3580 Ketchikan

19. (a) SEP 27 1945 (Date received local registrar) (b) J. F. Bredbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th
year 1945 hour 12:45 minute P. M.

21. I hereby certify that I attended the deceased from 9/14/45
19____ to 9/19/45 19____
that I last saw him alive on 9/19/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death. Arteriosclerotic heart disease

Due to _____

Due to 93h

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature James J. South (M. D. or other)

Address 1515 Lafayette 9/19/45

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

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.....

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.