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DOM-5-43
ev. 5-17-39
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#45893
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29326**
Registrar's No. **8380**

FILED OCT 6 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis, Missouri**
(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 **9 days** (Specify whether
In this community **Unk.**
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")
Street No. **City Infirmary** (If rural, give location)
(d) Citizen of foreign country? **Unk.** (Yes or No)
If yes, name country.

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

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **male**
6. (b) Name of husband or wife **Unk.** 6. (c) Age of husband or wife if alive **12** years
7. Birth date of deceased **Jan. 12 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 8 4 hr. min.

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

10. Usual occupation **Unk.**

11. Industry or business

12. Name **Unk.**

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

14. Maiden name **Unk.**

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

16. (a) Informant: **M. Renard**

(b) Address **St. Louis City Hospital**

17. (a) **Anatomical Board** Date thereof **9 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director **W. T. ...**

(b) Address **3500 ...**

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

20. DATE OF DEATH: Month **Sept.** day **16th**
year **1945** hour **10:25** minute **A.** M.
21. I hereby certify that I attended the deceased from **9/8/45**
19... to **9/16/45** 19...
that I last saw him alive on **9/16/45** 19...
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of head of pancreas**
Due to...
Due to... **46 g**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations...
Of autopsy...
Duration
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)

23. Signature **J. F. ...** (M. D. or other)

Address **1515 Lafayette**

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

MOTHER FATHER

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.