

S. No. 2
OM-5-43
v. 5-17-39
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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31854

FILED NOV 10 1945
318

State File No. _____
Registrar's No. 9409

Primary Registration District No. 1003

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

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:
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 3 days
(Specify whether _____)

In this community 10 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 317
(If outside city or town limits, write "RURAL")

(d) Street No. 6012 Fyler Ave. 9
(If rural, give location)

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

3. (a) PRINT FULL NAME AUGUST FAVRE

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Louise

6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

7. Birth date of deceased Dec 6 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81 10 23 _____ hr. _____ min.

9. Birthplace Switzerland 5
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Emile Favre

13. Birthplace Switzerland 5
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Perrie

15. Birthplace France 5
(City, town, or county) (State or foreign country)

16. (a) Informant Bertha Favre

(b) Address 6012 Fyler Ave.

17. (a) Burial (b) Date thereof 11/1/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) OCT 31 1945 J. F. Bredick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th
year 1945 hour 5:15 minute P. M.

21. I hereby certify that I attended the deceased from 10/26/45
19____ to 10/29/45 19____

that I last saw him alive on 10/29/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death generalized arteriosclerosis

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Harold C. Grit 1315 Lafayette 10/30/45
Date signed _____

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

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 *O. W. Cooper*
Licensed Embalmer No. *3830*
P. O. Address *2301 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.