

S. No. 2  
OM-2-43  
v. 5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. **32139**  
Registrar's No. **9174**

Registration District No. **1003** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis Mo**

(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:  
**3923 Chippewa St**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County \_\_\_\_\_

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

(d) Street No. **3923 Chippewa St**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **Elizie Virgil Mc Ginnis**

3. (b) If veteran, name war **World War # 1** 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Esther** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **July 21 1886**  
(Month) (Day) (Year)

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

**59 3 1** hr. \_\_\_\_\_ min.

9. Birthplace **St. Louis Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Asst Engineer**

11. Industry or business **Jefferson Barracks**

MOTHER FATHER

12. Name **John W Mc Ginnis**

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

14. Maiden name **Katherine Essen**

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

16. (a) Informant **Katherine Essen**  
(b) Address **Philadelphia Penn**

17. (a) **Burial** (b) Date thereof **10 26 45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **Kriegshauser**  
(b) Address **4228 So. Kingshighway**

19. (a) **OCT 24 1945** (b) **J. F. Predeck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22**  
year **1945** hour **11.50 AM** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **Sept 5 1945** to **Oct 22 1945**  
that I last saw him alive on **Oct 20 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Hypertension severe**

Other conditions **Atherosclerosis mild**  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(a) Means of injury \_\_\_\_\_

23. Signature **Paul A. Raus** (M. D. or other) **M.D.**  
Address **3115 So. Grand** Date signed **10/23/45**

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

OCT 29 1945

1600  
17  
9  
0

Dr Remus  
3115 So. Grand

**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 *Richard W. Storrsand*

Licensed Embalmer No. *4007*

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32139-45

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9174

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:.....  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Clara Virgil Mc Ginnis

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER  
12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant Clara Mc Ginnis  
(b) Address 3923 Chippewa

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) 20-30-45 (b) J. T. Bueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 22  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw h..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

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?  
..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)  
Address..... Date signed.....

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

SUPPLEMENTARY

