

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38634

State File No. _____

FILED NOV 17 1945

6076

Registrar's No. 2698

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town So. Kinloch, Park
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
So. Kinloch, Park / Residence
(If not in hospital or institution, write street number or location)

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

In this community 26 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town So. Kinloch, Park
(If outside city or town limits, write "RURAL")

(d) Street No. So. Kinloch, Park
(If rural, give location)

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

3. (a) PRINT FULL NAME Joseph Templeton

3. (b) If veteran, name war none

3. (c) Social Security No. 493-09-6642

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th
year 1945 hour 7 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
UNATTENDED

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race negro

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

6. (b) Name of husband or wife Rosie Templeton

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Nov. 5 1881
(Month) (Day) (Year)

Immediate cause of death auricular fibrillation

Duration _____

8. AGE: Years 63 Months _____ Days 3 If less than one day _____ hr. _____ min.

Due to Syphilitic heart disease

Due to _____

Other conditions: 302
(Include pregnancy within 3 months of death)

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

10. Usual occupation Houseman

11. Industry or business Hotel Jefferson

12. Name Edd Templeton

13. Birthplace Lawrence, So. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Sanders

15. Birthplace Lawrence, So. Carolina
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations None

Of autopsy _____

16. (a) Informant Rosie Templeton

(b) Address So. Kinloch, Park, Mo.

17. (a) removal (b) Date thereof 11-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morrilton, Ark.

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? _____

18. (a) Signature of funeral director Lee J. Sneed

(b) Address 3615 Easton Ave

19. (a) 11-10-45 (b) Dr. D. D. Derran, M.D.
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Marion Friedman (M. D. number) _____
Address St. Louis County Health Dept. Date signed 11/9/45

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

MOTHER FATHER

96
0
0

96
0
0

MAY 19 1944

MAY 19 1946

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..... *Charles L. Howell*

Licensed Embalmer No. *2452*

P. O. Address..... *2834 Sample*

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.