

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39486**
Registrar's No. **11492**

FILED JAN 21 1946

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(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 _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
Street No. Unknown
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT MCKAY
(b) If veteran, name war ---
(c) Social Security No. ---

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 12th
year 1945 hour 4:00 minute P M.
21. I hereby certify that I attended the deceased from 12/7/45
1945 to 12/12/45 1945
that I last saw him im alive on 12/12/45 1945
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Unknown
(b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 10th, ?
(Month) (Day) (Year)

Immediate cause of death Broncho pneumonia
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 107
Major findings: Of operations _____
Of autopsy not performed

8. AGE: Years 65? Months --- Days --- If less than one day hr. _____ min. _____
9. Birthplace Unknown (City, town, or county) (State or foreign country) 9

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

10. Usual occupation Unknown
11. Industry or business _____
12. Name George
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
14. Maiden name Evelyn Unknown (City, town, or county) (State or foreign country)
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Anatomical Board (b) Date of removal 12-17-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis City Hospital

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 J. F. Breese 1515 Lafayette 12/15/45 (or other) _____
Address _____ Date signed _____

18. (a) Signature of funeral director J. F. Breese
(b) Address 3500 Lafayette
19. (a) DEC 28 1945 (b) Registrar's signature J. F. Breese
(Date of death registered) (Registrar's signature)

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.