

S. No. 2
DM-5-43
v. 5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39700**
Registrar's No. **11190**

FILED JAN 5 1946
Registration District No. **318**

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, Missouri**
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(d) Length of stay: In hospital or institution..... **25 days**
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **Missouri** (b) County.....
(c) City or town..... **St. Louis**
(d) Street No. **1219 So. 9th St., Memorial**
(e) Citizen of foreign country? **No**
If yes, name country.....

3. (a) PRINT FULL NAME..... **BEN ROARK**
3. (b) If veteran, name war.....
3. (c) Social Security Pensioner..... **Pensioner**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **16th**
year **1945** hour **2:40** minute **P** M.
21. I hereby certify that I attended the deceased from **11/21/45**
19..... to..... **12/16/45** 19.....
that I last saw him alive on..... **12/16/45** 19.....
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 **Widower**
6. (b) Name of husband or wife..... **Unknown** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... **May 2nd, ?**
(Month) (Day) (Year)

Immediate cause of death.....
arteriosclerotic Heart Disease

8. AGE: Years **abt - 79** Months **-** Days **-** If less than one day hr. min.

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

9. Birthplace..... **Kentucky** (City, town, or county) (State or foreign country)
10. Usual occupation..... **Pensioner**

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN.....
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
11. Industry or business.....
12. Name..... **James**
13. Birthplace..... **Kentucky** (City, town, or county) (State or foreign country)
14. Maiden name..... **Mary** **Unknown**
15. Birthplace..... **Kentucky** (City, town, or county) (State or foreign country)
16. (a) Informant..... **M. Renard**
(b) Address..... **St. Louis City Hospital**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof..... **12-20-45** (Month) (Day) (Year)
(c) Place: burial or cremation..... **Memorial Park Cem.**
18. (a) Signature of funeral director..... **Albert H. Hoppe**
(b) Address..... **4700 Washington Blvd.**
19. (a) **DEC 20 1945** (Date received local registrar) **J. Bredsch** (Registrar's signature)

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?..... Means of injury.....
23. Signature..... **Max C. Starkloff** Date signed..... **12/17/45**

No Embalm

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.