

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 5 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 2002

Registrar's No. 961

1. PLACE OF DEATH

(a) County St. Louis Co.
(b) City or town University City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6940 Columbia
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Since 1885
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
(c) City or town University City 3
(If outside city or town limits, write "RURAL") 5
(d) Street No. 6940 Columbia
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Coxe Travilla

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Mary Moffit, Dec. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 1865 July 11
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 6 18 hr. _____ min.

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

10. Usual occupation Sec'y

11. Industry or business Pilot Knob Oil Co.

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

16. (a) Informant James C. Travilla, Jr.

(b) Address 6940 Columbia

17. (a) burial (b) Date thereof Jan. 31-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Alexander Doro

(b) Address 6175 Delmar

19. (a) 1-31-46 (b) E. D. Dr. Haraway
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29
year 1946 hour 9: minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov. 20, 1945, to Jan. 29, 1946;
that I last saw him alive on Jan. 29, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion, Acute Chronic myocarditis
Due to Senility 940
Due to _____

Duration
10 days
4 yrs.

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

Major findings: Of operations None

Of autopsy None

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

* 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 Sam A. Danell (M. D. or other) M.D.
Address 1200 S. Big Bend Blvd. Date signed 1/30/46

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

2039

FEB 23 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

Joe E. McCulloch

Licensed Embalmer No. *2460*

P. O. Address *6175 Palma*

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.