

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11201**
Registrar's No. **2798**

FILED MAR 30 1946
Registration District No. **38**

Primary Registration District No. **100**

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
(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 Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3872 Shaw Boulevard 179
Memorial (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME MICHAEL J. HART

3. (b) If veteran, name war _____

3. (c) Social Security No. 493-01-9148

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Valley Hart

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

7. Birth date of deceased July 14-1986
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
year 1946 hour 9:05 minute P M.

21. I hereby certify that I attended the deceased from 2/16/46
to 3/23/46, 19____, to 3/23/46, 19____;

that I last saw him alive on 3/23/46, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>8</u>	<u>9</u>	hr. min.

Duration _____

Due to _____

Due to _____

Other conditions Anteriorly Heart Disease
(Include pregnancy within 3 months of death)

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

10. Usual occupation Maintenance Man

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Michael J. Hart

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

14. Maiden name Ellen Monroe

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

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? _____

16. (a) Informant Mrs Valley Hart

(b) Address 3872 Shaw Boulevard

17. (a) Burial (b) Date thereof 3-26-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

While at work? _____ (Specify type of place)

Means of injury 0

23. Signature Phil F. D. Sait (M. D. or other) M.D.

Address 1420 Gilman Date signed 3/25/46

18. (a) Signature of funeral director Wm L. Maydel

(b) Address 1926 Allen Avenue

19. (a) MAR 25 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

10113
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Benj. C. Duncan*

..... Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

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.