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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38308

FILED DEC 32 1946

Registration District No. _____ Primary Registration District No. 6076 Registrar's No. 3339

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: Since 10-20-46 (Specify whether years, months or days)

In this community: 46 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: _____

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

(d) Street No.: 5139 Ridge Ave.,
(If rural, give location)

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

If yes, name country: _____

3. (a) PRINT FULL NAME: TRAVERS, Theobald Matthew

3. (b) If veteran, name war: World I

3. (c) Social Security No.: Unknown

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: April 3, 1900 (Month) (Day) (Year)

8. AGE: Years 46 Months 7 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace: St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Salesman

11. Industry or business: _____

FATHER
12. Name: James Travers
13. Birthplace: ~~Unknown~~ Ireland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: ~~Unknown~~ Elizabeth Stanley
15. Birthplace: ~~Unknown~~ Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant: Registrar, Vet. Adm. Hospital,
(b) Address: Jefferson Barracks, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-23-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cem.

18. (a) Signature of funeral director: Edgar F. Stuart
(b) Address: 1225 Union Blvd.

19. (a) 11-25-46 (Date received local registrar) (b) Ruth Allen M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20, year 1946 hour 6:05 minute P M.

21. I hereby certify that I attended the deceased from October 20, 1946 to November 20 1946 that I last saw him alive on November 20 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
CIRRHOSIS OF LIVER; RUPTURED ESOPHAGEAL VARICES	UNK.
Due to:	
Due to:	
Other conditions: DIABETES AND DIABETIC COMA (Include pregnancy within 3 months of death)	
PULMONARY EDEMA	UNK.

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

Major findings: Of operations: None

Of autopsy: Autopsy performed (See cause of death.)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): No

(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? (Specify type of place)

While at work? (e) Means of injury: _____

23. Signature: L. E. Stilwell, M. D. (M. D. or other)

Address: Vet. Adm. Hosp., Jeff. Brks., Mo Date signed: 11-21-46

(Licensed Embalmer's Statement on Reverse Side)

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 John S. Glennek

Licensed Embalmer No. 4194 C

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.