

No. 2  
12-45  
17-39  
X47076

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 17 1947 318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7035  
Registrar's No. 1207

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County ST. LOUIS, MO.  
(b) City or town (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST. LOUIS CITY HOSPITAL, MAX STARKLOFF  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days MEMORIAL (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM TEMME  
3. (b) If veteran, name war. 3. (c) Social Security No. OAA

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
abt - 73?

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

10. Usual occupation Unknown

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital.

17. (a) (Burial, cremation, or removal) (b) Date thereof Feb 17 1947 (Month) (Day) (Year)  
(c) Place: Burial or cremation Anatomical Board St. Louis

18. (a) Signature of funeral director W. T. ...  
(b) Address 3500 ...

19. (a) FEB 5 1947 (Date received local registrar) (b) J. F. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County  
(c) City or town St. Louis 26 17 (If outside city or town limits, write "RURAL")  
(d) Street No. 2100 1/2 Blair Ave., 9 0 (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 2, year 1947 hour 3:45 minute A M.  
21. I hereby certify that I attended the deceased from 1-25-47 to 2-2-47, 19... that I last saw him alive on 2-2-47, 19... and that death occurred on the date and hour stated above.  
Immediate cause of death

Arteriosclerotic Heart Disease

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations  
Of autopsy

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

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 W. W. ... (M. D. or other)  
Address 1515 LAFAYETTE Date signed 2-3-47

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



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**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.**