No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947

Registration District No. 3/1

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 11941

Registrar's No. 640

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Kos, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 47 Days (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: 17
(c) City or town: St Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 1601 South 11th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: IRVIN William Louis
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: M
5. Color or race: W
6. (a) ~~Single, widowed~~, married, ~~divorced~~: M
6. (b) Name of husband or wife: Edna Barbeau IRVIN
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March (Month) 27 (Day) 1918 (Year)

8. AGE: Years 28 Months 11 Days 19 If less than one day hr. min.

9. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Truck driver
11. Industry or business:
FATHER
12. Name: Arthur Irvin
13. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name: Grace McDonald
15. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Robert Koch Hospital Records
(b) Address:
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: March 19 47 (Month) (Day) (Year)
(c) Place: burial or cremation: New S.S. P & P. Cem.
18. (a) Signature of funeral director: E. J. Schnur
(b) Address: 3125 Lafayette Av
19. (a) 3-19-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16 year 1947 hour 11 minute 45 A.M.
21. I hereby certify that I attended the deceased from 1-28- 1947 to 3-16 1947; that I last saw him alive on 3-16 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to 13 b	7 months
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: John T. Kelly M.D. (M. D. or other)
Address: Robert Koch Hospital Date signed 3/16-47

(Licensed Embalmer's Statement on Reverse Side)

APR 21 1947

APR 28 1947

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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave

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.