

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25821**
Registrar's No. **7078**

FILED AUG 8 1947
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH: **St. Louis**

(a) County **City Hosp #1** **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **City Hospital #1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community **38 Hrs**
years, months or days

3. (a) PRINT FULL NAME **Joseph Magar**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **Non**

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Nov. 5th 1871**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
75	8	34		hr. _____ min.

9. Birthplace **Ill.** **Retired**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Henry Joseph Magar**

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

14. Maiden name **Catherine Spring**

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

16. (a) Informant **Mrs J. Huber**

(b) Address **2835 Keokuk**

17. (a) **Burial** (b) Date thereof **8-1-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **S, Peter & Paul Cem**

18. (a) Signature of funeral director **Wingbermuehle Funeral Home**

(b) Address **3819 S. Grand Blvd**

19. (a) **JUL 30 1947** (b) **J. F. Bradeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

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

(d) Street No. **24** **2835 Keokuk**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29**
year **1947** hour **7/27** minute _____ M.

21. I hereby certify that I attended the deceased from **July 28**, 1947, to **July 29**, 1947
that I last saw him alive on **July 29**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: **Peripheral vascular collapse**

Due to **Heat prostration**

Due to **And arteriosclerotic heart disease**

Other conditions **undiagnosed psychosis**
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

23. Signature **Cecilia Hyman** M. D. or other _____
Address **1515 Lafayette** **7/30/47**
Date signed

Handwritten mark

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..... *J. Allen Davis*

Licensed Embalmer No. *4053*

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.