

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED SEP 13 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No.

27803

Registrar's No.

7637

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County 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: 1316 So. 3rd St.
(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 days3: (a) PRINT
FULL NAME

3: (b) If veteran,

name war

4. Sex

Male

6: (b) Name of husband or wife

7. Birth date of deceased

8. AGE:

Years

Months

Days

9. Birthplace

Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

3: (c) Social Security No.

6: (a) Single, widowed, married,

divorced

6: (c) Age of husband or wife if

alive

(Month) (Day) (Year)

If less than one day

hr. min.

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

State or foreign country

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1316 So. 3rd St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Month August day 3
year 1948 hour 8 minute 30 M.21. I hereby certify that I attended the deceased from
_____, 19____, to _____, 19____;that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

1. Edema of Brain2. Pulmonary Edema3. Chronic Myocarditis

Due to _____

Due to _____

Other conditions

(Include pregnancy within 6 months of death)

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(City or town) (County) (State)

(City or town) (County) (State)

(City or town) (County) (State)

(City or town) (County) (State)

(City or town) (County) (State)

(City or town) (County) (State)

(City or town) (County) (State)

(City or town) (County) (State)

(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 Ralph W. Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, Mo

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.

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.

Sept
7637

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

- (a) County 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:
(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)

3. (a) PRINT
FULL NAME

John Hemmer

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 single

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: 84 Years Months Days If less than one day _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (If not, date of death)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1948 Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

- Due to _____

- Due to _____

- Other conditions _____
(Include pregnancy within 3 months of death)

- Major findings:
Of operations _____

- Of autopsy _____

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 _____

- Signature _____ (M. D. or other) _____

- Address _____ Date signed _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

SUPPLEMENTARY

SEP 15 1948

S-27803

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