

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34087

FILED NOV 12 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9411

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff;
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days Memorial
In this community 33 years 7 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ^{Mad} ₁₇
(c) City or town St. Louis (If outside city or town limits, write "RURAL") ₉
(d) Street No. 2102 Lafayette Ave., (If rural, give location) ₁₀
(e) Citizen of foreign country? 23 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CORRINNE DUPHAY

3. (b) If veteran, name war. --- 3. (c) Social Security No. ---

4. Sex Male (1) 5. Color or race White
6. (a) Single, widowed, married, divorced. 2 Widowed
6. (b) Name of husband or wife. unknown 6. (c) Age of husband or wife if alive. --- years
7. Birth date of deceased. May 22nd (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 - 76 - - hr. min.

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

10. Usual occupation OAA

11. Industry or business

12. Name Robert Green 9

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

14. Maiden name Sara 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) Anatomical Board (b) Date thereof OCT 31 1948 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) OCT 31 1948 (b) J. B. [Signature] (Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3rd year 1948 hour 6 minute 20 A. M.

21. I hereby certify that I attended the deceased from 9/9/48, 1948, to Oct. 3rd, 1948, that I last saw her alive on Oct. 3rd, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death: Anemia

Due to: WI

Other conditions: Diabetic Mellitus -

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?

While at work? (Specify type of place) (e) Means of injury 0

23. Signature [Signature] 1515 Lafayette (M. D. or other)

Date signed 10/4/48

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

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.