S. No. 2
-11-10-39
5-17-39
P I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JUL 15 19

State File No. 22806

Registration District No. 784 Primary Registration District No. 203 Registrar's No. 1148

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch (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 19 days (Specify whether years, months or days) In this community 19 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1527A Rear Pine Street (If rural, give location)
(e) If foreign born, how long in U. S. A.? 32 years.

3. (a) PRINT FULL NAME JOHN ENGLAND 524

3. (b) If veteran, name war None

3. (c) Social Security No. No

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 August (Month) 23 (Day) 1869 (Year)

8. AGE: Years 70 Months 9 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) Sweden (State or foreign country) 7

10. Usual occupation Laborer 7

11. Industry or business Asbestos Industry 7

FATHER
12. Name Andrew England 7
13. Birthplace (City, town, or county) Sweden (State or foreign country)

MOTHER
14. Maiden name Marie Hanson
15. Birthplace (City, town, or county) Sweden (State or foreign country)

16. (a) Informant Hospital Records -
(b) Address Koch Hospital, Koch, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-40 (Month) (Day) (Year)
(c) Place: burial or cremation Lemay Cemetery

18. (a) Signature of funeral director Bredenmeyer Funeral Home
(b) Address 1936 St Louis Ave St Louis Mo

19. (a) JUN 17 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1940 hour 7 minute 40 P.M.

21. I hereby certify that I attended the deceased from May 18, 1940, to June 5, 1940; that I last saw him alive on June 5, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchiectasis	20 yrs
Due to: Generalized arteriosclerosis	7
Due to: Pulmonary tuberculosis, activity questionable	?
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
Of autopsy: Bronchiectasis, generalized arteriosclerosis	

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 Clyde R Mylander (M. D. or other) MD
Address Koch Hospital Koch Mo Date signed 6-7-40

(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.....

.....None....., 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, above space should be left blank.