N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D OCT 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791

30796
Do not use this space.

Registration District No. 1008

Primary Registration District No.

Registered No. 8233

1. PLACE OF DEATH

(a) County

(b) Township

(c) City St. Louis, Mo. (d) Street No. City Hospital #1. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Dace

(a) Residence, No. 3505 Iowa Street St. 24
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ava Dace

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 20/ 1882

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
56	1	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 1934

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Bonne Terre
(STATE OR COUNTRY) Missouri

FATHER

13. NAME Geo W. Dace

14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Laura Clayborn

16. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Virginia.

17. INFORMANT Katie Dace
(ADDRESS) 3505 Iowa, Street.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hopewell, Missouri DATE Sept. 20/ 1938

19. FUNERAL DIRECTOR Albert H. Hoppe, Inc.
(ADDRESS) 429 N. Euclid, Ave.

20. FILED SEP 19 1938 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 17/ 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 8:25 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Hypertrophy	
Prostatic Hypertrophy	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Alfred J. Perry, M. D.

(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No. .....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by .....

..... L. E. .....

No. ..... or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed Albert L. Hoppe

Licensed Embalmer No. 2971

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)