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 DEC 12 1939

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

37197
Do not use this space.

1. PLACE OF DEATH

(a) County ..... 1 Registration District No. 791

(b) Township ..... 2 Primary Registration District No. 1003 Registered No. 9524

(c) City St. Louis (d) Street No. U.S. Marine Hospital 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 yrs. mos. 11 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 532 Owen Endicott

(a) Residence, No. 30 Sycamore st. St. NR Evansville, Indianna
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May 19, 1890

7. AGE: 48 YEARS, 5 MONTHS, 10 DAYS; If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Watchman
9. Industry or business in which work was done, as saw mill, bank, etc.: Aboard River Steamer.
10. Date deceased last worked at this occupation (month and year): 10-1-1938
11. Total time (years) spent in this occupation: Unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Ind.

FATHER
13. NAME: Samuel Endicott
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Ind.

MOTHER
15. MAIDEN NAME: Angeline Vaughn
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Ind.

17. INFORMANT (ADDRESS): Clinical Records, U.S. Marine Hospital, St. Louis, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. MATTHEWS CEM. DATE NOV. 2, 1938

19. FUNERAL DIRECTOR (ADDRESS): C. Hoffmeister U. & L. Co. 7814 S. Broadway

20. FILED NOV 2 1938, 19..... J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Oct. 29, 1938, 19

22. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1938, 19, to Oct. 29, 1938, 19. I last saw him alive on Oct. 29, 1938, 19. Death is said to have occurred on the date stated above, at 12:45 P.N.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Syphilis, cardio-vascular.	Unknown

Other contributory causes of importance:

Coronary occlusion.	10/29/38
Hernia, umbilical	Unknown
Obesity	Unknown

Name of operation ..... Date of .....
What test confirmed diagnosis? Autopsy and laboratory & Phy. 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 No, 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) C. Y. Bailey, Surg. (R) USPHS, M. D.
(Address) US Marine Hospital, St. Louis, Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, George W. Hoffmeister, Licensed Embalmer No. 2426

hereby certify that the body recorded on the reverse side of this certificate was embalmed by L. C. Hoffmeister 3871

L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 2426

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.)