

REC'D FEB 10 1939

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

*Shippes*

170 Do not use this space.
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**1. PLACE OF DEATH**

(a) County \_\_\_\_\_ Registration District No. **791**  
 (b) Township \_\_\_\_\_ Primary Registration District No. **1003**  
 (c) City ST. LOUIS, MISSOURI (d) Street No. BARNES HOSPITAL St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 400 Hubert R. Hall St. **NR Springfield Illinois**  
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
About 58

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. unknown  
 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) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

FATHER 13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

MOTHER 15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

17. INFORMANT (ADDRESS) J. C. Stetsman M.D. Barnes Hospital

18. BURIAL, CREMATION, OR REMOVAL Springfield Ill DATE 1-7-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe 4700 Washington

20. FILED JAN 5 1939 J. D. Bredeh Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-4-39 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-4-39, 1939, to 1-4-39, 1939.

I last saw him alive on 1-4-39, 1939. Death is said to have occurred on the date stated above, at 2:55 p.m.

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

**CARCINOMA OF THE LARYNX & STENOSIS OF THE LARYNX** Date of onset 11 yrs ago

Other contributory causes of importance:

Name of operation BRONCHOSCOPY TRACHEOTOMY Date of 1-4-39

What test confirmed diagnosis? LAB 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 \_\_\_\_\_, 1939

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? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) A. Stetsman, M. D.

(Address) BARNES HOSPITAL

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.

**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.....

*Albert G. Hays*

Licensed Embalmer No.....

2971

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.**