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 MAR 13 1939

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

4638
Do not use this space.

791
1003
1331

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. .....
(c) City ST. LOUIS (d) Street No. 4303 McPHERSON AVE. 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 55 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? 62 yrs. mos. ds.

2. PRINT FULL NAME JOSEPH COMERCE.
(a) Residence, No. 4303 McPHERSON AVE. St. 19
(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): FEBRUARY 22ND 1876
7. AGE: YEARS 62 MONTHS 11 DAYS 18 If LESS than 1 day, — hrs. or — min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEMANN
9. Industry or business in which work was done, as saw mill, bank, etc. PRIVATE HOME.
10. Date deceased last worked at this occupation (month and year) FEB. 1939.
11. Total time (years) spent in this occupation 6 YRS

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): PENNSYSLVANIA.

FATHER
13. NAME IGNATIUS KOMMEROWSKI.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): GERMANY.

MOTHER
15. MAIDEN NAME FRANCES DOEHR.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): GERMANY

17. INFORMANT (ADDRESS) Mary C. Comerce 4303 McPherson.
18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE FEB. 11TH 1939
19. FUNERAL DIRECTOR (NAME) BROCKLAND UNDCO. (ADDRESS) 1827 HOGAN ST.
20. FILED ..... 19 ..... J. F. Budrick Local Registrar.
FEB 10 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB. 10TH 1939.
22. I HEREBY CERTIFY, That I attended deceased from JANUARY 15, 1935, to JANUARY 30, 1939
I last saw him alive on JANUARY 30, 1939. Death is said to have occurred on the date stated above, at 7:30 A. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis	JAN 15 '35
Angina Pectoris	

Other contributory causes of importance: Hypertension

Name of operation — Date of .....
What test confirmed diagnosis? E.K.G. Was there an autopsy? no

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) D. B. Havan, M. D.
(Address) Humboldt Bldg. per M. D. R.

(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, Me.

——, or by ——

Registered Apprentice No. ——, working under my personal supervision.

Signed John B. Brockland

Licensed Embalmer No. #93

P. O. Address St Louis, Mo

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

If this body is not embalmed, above space should be left blank.