

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.

APR 12 1939

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

M. H. Tausig.  
791  
1008

9179  
Do not use this space.  
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1. PLACE OF DEATH

(a) County 1 Registration District No. 2  
(b) Township 2 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
(c) City St Louis, Mo. (d) Street No. Jewish 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

435 Otto W. Maulding  
(a) Residence, No. \_\_\_\_\_ St.  NR Mt. Vernon, Ill.  
(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) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Inez Maulding  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17, 1895  
7. AGE YEARS 43 MONTHS 5 DAYS 10 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as Foreman  
9. Industry or business in which work was done, as R R Car Shop  
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) Mt Vernon Illinois

FATHER 13. NAME Joseph Maulding  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Henry Crawford Mt Vernon, Ill.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Vernon Ill DATE 3-28 1939

19. FUNERAL DIRECTOR (ADDRESS) Myers Funeral Service Mt Vernon, Illinois

20. FILED MAR 29 1939 J. P. Buchheit Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-27 1939  
22. I HEREBY CERTIFY, That I attended deceased from March 20, 1939, to March 27, 1939  
I last saw him alive on March 27, 1939. Death is said to have occurred on the date stated above, at 5-6 m.  
The principal cause of death and related causes of importance were as follows:

Erysipela, no pneumonia non tubercular 1939  
Other contributory causes of importance: lung abscess 1939

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) Albert E. Tausig M. D.  
(Address) 4500 Olive St. Louis

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**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 *Howard P. Rowland*

Licensed Embalmer No. *3114*

**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.)**