

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 APR 12 1939

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS 791
CERTIFICATE OF DEATH 1008**

9267
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **3032**
 (c) City St. Louis, Mo. (d) Street No. About City Sanitarium St. Sanitarium
 (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 10 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Mick

(a) Residence, No. 2007 Chestnut St. 21 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) About 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 62 - -

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. Unknown
 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) Unknown

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) John B. Varher, M.D.
5400 Arsenal St

18. BURIAL, CREMATION, OR REMOVAL PLACE Woodlawn DATE 3/16/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. R. Rutter 3500 Ray

20. FILED MAR 31 1939 J. F. Buckner Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 4/39 19

22. I HEREBY CERTIFY, That I attended deceased from 7-1-38, 19, to 3-4-39, 19.

I last saw him alive on 3-4-39, 19. Death is said to have occurred on the date stated above, at 4:28 P.M.

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

Degenerative Heart Disease Date of onset 1-39
Senility 12-18-33x
Arteriosclerosis 12-18-33x
Pulmonary Edema

Other contributory causes of importance:
Senility 12-18-33x
Arteriosclerosis 12-18-33x
Pulmonary Edema

Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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?.....
 If so, specify.....
 (Signed) J. B. Varher, M. D.
 (Address) City Sanitarium

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.....

Licensed Embalmer No.....

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.