

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.

21 1939

REC'D MAY 11 1939

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

16182
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
 (b) Township Carondelet Primary Registration District No. 300
 (c) City Keate (d) Street No. Robert Koch Hospital Registered No. 715
 (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. 1 mos. 8 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

355 Glossop Edmund
 (a) Residence, No. 3 Ashon Shelter St. (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 ?
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1876
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
63 ? ? ?
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ?
 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) St. Louis Mo.
 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) Koch Hospital Records
 18. BURIAL PLACE (NAME OF PLACE) (DATE) Memorial Park Cem. 4/22/39

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-19 1939
 22. I HEREBY CERTIFY, That I attended deceased from 3-11-39, 19... to 4-19-39, 19...
 I last saw him alive on 4-19-39, 19... Death is said to have occurred on the date stated above, at 7:10 a.m.
 The principal cause of death and related causes of importance were as follows:
Pul. Tho. Intestinal Tho. Date of onset ?
23
 Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis? Aspiration Was there an autopsy?.....
 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) Fred P. Holdburg, M. D.
Robert Koch Hospital (Address)

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. W. McLaughlin
2301 Lafayette Ave
 APR 21 1939
 20. FILED DR. Myrtle... Local Registrar.

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 L. Q. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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

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