

K. 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.

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

DESD JUN 12 1939

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1008

16721  
Do not use this space.  
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**1. PLACE OF DEATH**

(a) County..... / Registration District No.....  
 (b) Township..... / Primary Registration District No..... Registered No.....  
 (c) City St. Louis / (d) Street No. City Hospital No. 1 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** 526 John Danuser

(a) Residence, No. 1109 Paul Street 12 (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) separated  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Husband of Florence  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 9, 1876  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 62 7 27  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Watchman  
 9. Industry or business in which work was done, as saw mill, bank, etc. nil  
 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) Missouri

FATHER 13. NAME John Danuser

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

MOTHER 15. MAIDEN NAME Barbara Mann

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL OR CREMATION OF REMAINS PLACE St. Matthews DATE 5/8/39  
 (Specify name of place)

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. W. McLaughlin  
2301 Lafayette Ave

20. FILED MAY 8 1939 J. D. [Signature] Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/6/39, 19...  
 22. I HEREBY CERTIFY, That I attended deceased from 4/22/39, 19... to 5/6/39, 19...  
 I last saw him alive on 5/6/39, 19... Death is said to have occurred on the date stated above, at 5.40 P.M.  
 The principal cause of death and related causes of importance were as follows:

Degenerative Heart Disease

Other contributory causes of importance:  
Chronic Ischemic Nephritis

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... 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?.....  
 If so, specify.....  
 (Signed) William Sapsin, M. D.

(Address) City Hospital No. 1

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**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 Paul A Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayette

**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.**