

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

**791**

1. PLACE OF DEATH:

(a) County St Louis Mo  
 (b) City or town St Louis Mo  
 (c) Name of hospital or institution: Fort of Osceola Se 3  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) **PRINT** FULL NAME Unknown White Male

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Unknown  
 (Month) (Day) (Year)

8. AGE: Years about 38 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Henry Zaigert

(b) Address 6424 1/2

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Patersonfield

18. (a) Signature of funeral director Patersonfield

(b) Address 3029 Lafayette Ave

19. (c) JUN 26 1939  
 (Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Unknown (b) County Unknown  
 (c) City or town Unknown  
 (d) Street No. Unknown  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1939 hour 7 minute 00 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation due to

drowning

Due to trauma caused and manner

Due to could not be determined

Other conditions (Include pregnancy within 3 months of death) found in message

Major findings: Fort of Osceola Se

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (b) Means of injury 1/2

23. Signature Joseph M. Zaigert (M.D. or other)

Address Deputy Coroner Date signed 6/20

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 1-1939

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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.....

.....  
working under my personal supervision.

..... Registered Apprentice No.....

*W. J. Elbalmid.*  
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.**