

REC'D AUG 11 1939

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

24060

Registrar's No.

6333

Registration District No.

Primary Registration District No.

## 1. PLACE OF DEATH:

(a) County.....  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis Children's Hospital /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 13 Hrs.  
 (Specify whether  
 In this community  
 years, months or days)

3. (a) PRINT FULL NAME Thomas Andrew Chartrand <sup>636</sup>3. (b) If veteran, name war No 3. (c) Social Security No. None4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased March 9th 1931  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
8 3 7 hr. \_\_\_\_\_ min.9. Birthplace Chicago Illinois  
(City, town, or county) (State or foreign country)10. Usual occupation Schoolboy 0

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

12. Name Archibald E. Chartrand13. Birthplace Eureka Mo.  
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth Loughron15. Birthplace Brooklyn N.Y.  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Archibald E. Chartrand(b) Address 6050 S. Sangamon St. Chicago17. (a) Burial (b) Date thereof 7-19-39  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Pacific Missouri18. (a) Signature of funeral director Kriegshauser Mortuar(b) Address 4228 So. Kingshighway19. (a) JUL 18 1939 (b) J. F. Budnik  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois <sup>2</sup> (b) County \_\_\_\_\_  
 (c) City or town Chicago NR  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 6050 So. Sangamon St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th  
year 1939 hour 1 minute 0 A.M. 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: Haemorrhage Durationof the skull followingfractureof the skull followingfall from a height on aroof of a building at Eureka, Moon July 15-1939 exacttime unknown

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: Accident

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

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Accident

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 7-15-39(c) Where did injury occur? Eureka, Mo  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Yes Home  
(Specify type of place)(e) Means of injury fall23. Signature Joseph M. Deussen (M.D. or other)Address Deputy Coroner Date signed 7/17

**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 Edmund M. Hematt

Licensed Embalmer No. 3024

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.**