

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.

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30592  
Registrar's No. 7655

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

1. PLACE OF DEATH:

(a) County 2

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
1408 Louisville Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME JOHN H. HALE 450

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 Married

6. (b) Name of husband or wife Mabel Hale 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Mar. 29, 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52	5	4	hr. _____ min.
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9. Birthplace Marquard Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Police Officer, retired

11. Industry or business Metropolitan Police Dep't. 0

12. Name Steven J. Hale 0

13. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

14. Maiden name Rosa Hollis

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

16. (a) Informant's own signature Mabel Hale

(b) Address 1408 Louisville Ave.

17. (a) Burial (b) Date thereof 9-7-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fredericktown, Mo.

18. (a) Signature of funeral director Chas. J. Nixon, D. H.

(b) Address 4911 Washington Blvd.

19. (a) 9-5-39 (b) J. F. Bredock  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 1408 Louisville Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3-  
year 1939 hour 10:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from June 15-1939  
to Sept 3rd, 1939, at \_\_\_\_\_, 1939;

that I last saw him alive on Sept 1st 1939, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis digitans Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

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:

(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? 3 (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature W. F. Ceressey (M. D. or other) D.O.

Address 415 De Balincourt Date signed Sept 4, 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.....

....., 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.**