

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.

Registration District No. 1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH: 3

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: Gr. Coult. City Hospital  
(If outside city or town limits, write "RURAL" and name of township)

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

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

8. (a) PRINT FULL NAME Bennie Mason

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. 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 Unknown  
(Month) (Day) (Year)

8. AGE: 70 Years Months Days If less than one day \_\_\_\_\_ in \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business Unknown

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

18. 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 Walter Steba

(b) Address 5330 Senesque

17. (a) Removal (b) Date thereof Oct 3, 1939  
(Specify occasion, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis College of Eastern Pathology

18. (a) Signature of funeral director W. J. Friedrich

(b) Address \_\_\_\_\_

19. (a) OCT 3 1939  
(Date received local registrar)

J. F. Friedrich  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo (b) County \_\_\_\_\_

(c) City or town St. Louis [25]  
(If outside city or town limits, write "RURAL")

(d) Street No. 308 ELM  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 19  
year 1939 hour \_\_\_\_\_ minute 00 P. 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 Chronic Myocarditis

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

Due to arteriosclerosis

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

Major findings: 00  
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? \_\_\_\_\_

23. Signature Joseph M. Turner (Dr., P., or Other) 14

Address Deputy Coroner Date signed \_\_\_\_\_

**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 \_\_\_\_\_

*Raymond E. Schibe*

Licensed Embalmer No. \_\_\_\_\_

*3985*

P. O. Address \_\_\_\_\_

*St Louis Mo*

*city \_\_\_\_\_  
180*

**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.**