

STANDARD CERTIFICATE OF DEATH

34487

State File No.

9025

Registrar's No.

Registration District No.

791  
1009

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Peoples Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days) 40yrs

3. (a) PRINT FULL NAME Daniel Rollins 45

3. (b) If veteran, name war no 3. (c) Social Security No. NO

4. Sex Male 5. Color Col 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive 1892 years

7. Birth date of deceased March 23th (Month) (Day) (Year)

8. AGE: Years 47 Months 6 Days 20 If less than one day hr. min.

9. Birthplace Hot Springs Ark (City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business 1

12. Name Daniel Rollins

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

14. Maiden name Carrie Unknown

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

16. (a) Informant's own signature Marie Williams

(b) Address 2926 Lucas Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/39 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Randle & Son

(b) Address 3133 Bell Avenue

19. (a) OCT 24 1939 (Date received local registrar) (b) J. H. Randle (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 1  
(c) City or town St Louis 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2926 Lucas Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? Native years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19th year 1939 hour 10:45 PM minute M.

21. I hereby certify that I attended the deceased from 10-16-39 to 10-19, 1939  
that I last saw him alive on 10-18, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Puritic Heart Disease  
Due to Congestive Failure

Due to 10/18

Other conditions (include pregnancy within 3 months of death) 10/18  
Major findings: Of operations no operations  
Of autopsy not done

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury \_\_\_\_\_  
23. Signature Marion D. Little (M. D. or other) \_\_\_\_\_  
Address 3447 Pine St. Date signed 10-19-39

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

MARGIN RESERVED FOR BINDING

Rev. 5-17-39  
50M-5-17-39  
1 x 3111

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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 *Self, Watson*  
Licensed Embalmer No. *2698*  
P. O. Address *2769 Chouteau*

**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.**