

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.

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:
Firmin Desloge Hospital
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4255 Juniata St. 16
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Albert John Skay

8. (b) If veteran, name war None 8. (c) Social Security No. 4-92-10-6007

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

6. (b) Name of husband or wife Olga Skay 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased November 3rd 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 0 Days 6 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Structural Engineer

11. Industry or business Wm. B. Ittner Inc.

MOTHER FATHER { 12. Name John Skay 13. Birthplace Germany
(City, town, or county) (State or foreign country)

{ 14. Maiden name Louise Zintel 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Olga Skay
(b) Address 4255 Juniata St.

17. (a) Cremation (b) Date thereof 11-13-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory
Kriegshauser Mortuaries

18. (a) Signature of funeral director _____
(b) Address 4228 So. Kingshighway

19. (a) NOV 10 1939 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9th year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 7:30 AM to 4:30 PM that I last saw him alive on Nov 9 and that death occurred on the 9th day and hour stated above.

Immediate cause of death Brain tumor
secondary to tumor

Due to Brain tumor of choroid

Due to Brain tumor malignant

Other conditions (Include pregnancy within 3 months of death)

Major findings: Brain tumor
Of operations _____
Of autopsy same

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed Nov 10

Duration _____
PHYSICIAN _____
Underlying the cause to which death should be charged statistically.

Dr. Wm. J. Conybeare
in charge Body
3/30 to 5

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.