

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 12 1940

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 111722

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Baptist Hosp.
(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 Walter Close

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 Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 49 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Labourer

11. Industry or business _____

12. Name Unknown

18. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Pelestine Wahmeyer

(b) Address 3838 Oregon

17. (a) _____ (b) Date thereof 12-14-39 (Month) (Day) (Year)

(c) Place: burial or cremation Wash. Univ. Burial

18. (a) Signature of funeral director W. C. Kupper
(b) Address 3100 Kupper
19. (a) DEC 28 1939 (b) _____ (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1
(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2629 Howard
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 4
year 1939 hour 11 minute 40 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 Coronary sclerosis

Due to with chronic interstitial myocarditis

Due to Pyelonephrosis of right kidney

Other conditions Acute Parenchymatous Nephritis

Of autopsy Nephritis

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)

28. Signature Robert M. Johnson (M. D. or other)
Address Adair St Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE SURE EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. REV. 5-17-39 I 10951

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.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

SUPPLEMENTARY

Do not use this space.

1. PLACE OF DEATH

(a) County.....
 (b) Township.....
 (c) City.....
 (d) Street No. *Mo. Baptist Hospital* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. *Walter Close* St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX.....
 4. COLOR OR RACE.....
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word).....
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Avis Close* ^{age 40}
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *unknown*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
abt. 53

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....
 9. Industry or business in which work was done, as saw mill, bank, etc.....
 10. Date deceased last worked at this occupation (month and year).....
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

FATHER
 13. NAME.....
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

MOTHER
 15. MAIDEN NAME.....
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Matthews* DATE *2-9-40* 19.....

19. FUNERAL DIRECTOR (ADDRESS) *Croghan Und. Co*
7146 Manchester Ave

20. FILED **FEB 8 1940** Local Registrar.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-4* 19*39*

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury..... 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed)..... M. D.
 (Address).....

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK---THIS IS A CERTIFICATE OF DEATH. 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.

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S-412010

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed

Licensed Embalmer No.

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.)