

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

REC'D MAR 12 1940  
791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

4893

Registrar's No. \_\_\_\_\_

1723

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

Primary Registration District No. 1003

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:  
Desloge Hospital.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 Weeks.  
(Specify whether  
 In this community 33 Years.  
years, months or days)

3. (a) PRINT FULL NAME Dr. Louis E. Printy.

8. (b) If veteran, name war World 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 Anna Mae Printy. 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased October 31, 1889  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>50</u>	<u>3</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Physician.

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name John Printy.  
 { 18. Birthplace Iowa.  
(City, town, or county) (State or foreign country)

MOTHER FATHER  
 { 14. Maiden name Mary Teresa McGargill.  
 { 15. Birthplace Iowa.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Mae Printy

(b) Address #41 Vandeventer Place

17. (a) Burial (b) Date thereof Fe. 21, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) Feb 20 1940 (b) J. B. ...  
(Date registered in Registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. # 41 Vandeventer Place.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February, day 18th.  
 year 1940 hour 6. minute 15 p. M.

21. I hereby certify that I attended the deceased from 12/22, 1939, to Feb. 18, 1940;  
 that I last saw h. im alive on Feb. 18, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Biliary cirrhosis of liver Duration Uncertain

Due to Chronic Cholangitis and chronic pancreatitis Uncertain

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Yes.

22. If death was due to external causes, fill in the following: NO

(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 \_\_\_\_\_

28. Signature J. O. Brown (M. D. or other) \_\_\_\_\_

Address 1325 S. Grand Blvd Date signed 2/19/40

2011  
JAN  
15

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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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1723

I. 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: \_\_\_\_\_  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If rural, give location)  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Dr. Louis E. Printy

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
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 \_\_\_\_\_

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

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) Mar. 16, 1940 (b) J. J. Bredeck (Registrar's signature)  
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 18  
year 1940 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from 12/22, 1939, to 2/18, 1940;  
that I last saw him alive on 2/18, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Biliary cirrhosis of liver Uncertain  
Duration \_\_\_\_\_

Due to Carcinoma of head of pancreas II

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

Other conditions Chronic Cholangitis and chronic pancreatitis Uncertain  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Yes.  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: \_\_\_\_\_ No

(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 G. O. Brown (M. D. or other) MD

Address 1325 S. Grand Blvd. Date signed 3/15/40

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

SUPPLEMENTARY

SUPPLEMENTARY

S-4893

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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.)**

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