

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12438

State File No. _____

Registration District No. 784

Primary Registration District No. 112

Registrar's No. 716

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town ROCK HILL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
913 ROCK HILL ROAD
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
(Specify whether
In this community 15 DAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS
(c) City or town STEELEVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. KEYSVILLE ROAD
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME ARTHUR GALE DEYONG

3. (b) If veteran, name war _____
(c) Social Security No. 495-12-8126

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CHARLOTTE DEYONG 6. (c) Age of husband or wife if alive UNKNOWN years

7. Birth date of deceased DECEMBER-16-1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>3</u>	<u>25</u>	— hr. — min.

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

10. Usual occupation SALESMAN - RETIRED

11. Industry or business SWIFT-PACKING CO.

12. Name ADRIAN DEYONG

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

14. Maiden name FLANOR MCGOWAN

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

16. (a) Informant W. L. Dwyer

(b) Address 204 Lincoln - Webster Groves Mo

17. (a) BURIAL (b) Date thereof APRIL-13-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK HILL CEMETERY

18. (a) Signature of funeral director Parker and Co.

(b) Address Webster Groves Mo

19. (a) APR 13 1940 (b) R. M. Dwyer
(Date received local registrar) (Registrar's signature)

(Licensed Embalmers' Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr 10th day 10th year 1940 hour 6 A minute _____ M.

21. I hereby certify that I attended the deceased from Mar 25th 1940 to Apr 10th 1940

that I last saw him alive on Apr 10 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Lympho Sarcoma Duration 3 mo's
of mediastinum

Due to Myocarditis Chronic

Due to MI

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Lympho Sarcoma
of mediastinum

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? Yes

(Specify type of poison) _____ (e) Means of injury _____

23. Signature Ralph E. Gaston (M. D. or other) _____

Address Webster Groves Mo Date signed 4-12-40

Duration

3 mo's

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 E. G. Aldrich

Licensed Embalmer No. 1332

P. O. Address Webster Grove

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. 12438-7
Registrar's No. 716

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 754

Primary Registration District No. 112

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rock Hill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
913 Rock Hill Rd -
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
In this community 15 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Arthur DeYoung
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced M
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 62 Months 3 Days 25 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. 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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

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

2. USUAL RESIDENCE OF DECEASED: Crawford
(a) State Mo. (b) County St. Louis
(c) City or town Steelville
(If outside city or town limits write "RURAL")
(d) Street No. Keyville Rd -
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr. day 10 - year 40 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____

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

SUPPLEMENTARY

7940

S-12438