DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 13290

MAY 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3492

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.

**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: 1115a Dillon St 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 40 yrs
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County

(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")

(d) Street No. 6 1115a Dillon St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Chas. H. Rider 360

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Sarah

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Feb. 11, 1856
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 2 | 5 | hr. min. |

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

10. Usual occupation Chemist

11. Industry or business Retired

FATHER
12. Name John Rider
13. Birthplace New York /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace New York /
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nora Dowell
(b) Address 1115a Dillon St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/40
(Month) (Day) (Year)
(c) Place: burial or cremation Park Lawn Cem

18. (a) Signature of funeral director R. W. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) APR 17 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 16
year 1940 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec. 22, 1939, to April 16, 1940
that I last saw him alive on Apr. 16, 1940
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cancer liver | 3 mos |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN
Underline the cause to which death should be charged statistically

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 H. G. Frazer, M.D. (M. D. or other)
Address 1109 Chouteau Date signed April 17-1940

(Licensed Embalmer's Statement on Reverse Side)

## 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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayet

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**