

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 16180Registration District No. 784Primary Registration District No. 200Registrar's No. 845

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Jefferson Barracks
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Station Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 (Specify whether
 years, months or days)
 In this community 13 years. (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Doctor, Tom none.

3. (b) If veteran, name was no veteran 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if
Rowena Doctor alive -- years

7. Birth date of deceased June 2 1890
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>10</u>	<u>27</u>	hr. min.

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

10. Usual occupation Soldier,

11. Industry or business U. S. Army.

12. Name Unknown Doctor

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Rowena Doctor

(b) Address 9915 Linn Avenue

17. (a) Burial (b) Date thereof May 2, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetary

18. (a) Signature of funeral director [Signature]

(b) Address 7814 S. Broadway

19. (a) APR 30 1940 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town LeMay
 (If outside city or town limits, write "RURAL")
 (d) Street No. 9915 Linn Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. -- years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
 year 1940 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from April 22
1940 to April 29, 1940;
 that I last saw h im alive on April 29, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, ppl-
monary, chronic, active, involving
upper lobe rt lung, lower lobe left
lung, with cavity formation, left.

2. Coronary sclerosis, 3. Cardiac dil-
atation, acute, severe.

4. Spontaneous, massive collapse of
left lung.

Other conditions
 (Include pregnancy within 3 months of death)

Major findings: no operation 23

Of operations no operation
 Of autopsy Confirming above.

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 Phillip H. Nabbe (M. D. or other) 1

Address Jefferson Barracks, Mo. Date signed 4-30-40

MAY 31 1945

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. *Edwin H. Leibinger*

P. O. Address *6464 Clipperton*

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.