

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 mo. 14 days  
(Specify whether  
39 years  
years, months or days)

3. (a) PRINT FULL NAME Cornelius (Lawrence M.) Tack

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 single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 7, 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 5 29 hr. \_\_\_\_\_ min.

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

10. Usual occupation nil.

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

12. Name Martin Tack

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

14. Maiden name Elizabeth Cole

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

16. (a) Informant St. Louis County Hospital  
(b) Address Clayton, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-40  
(Month) (Day) (Year)

(c) Place: burial or cremation New York

18. (a) Signature of funeral director Louis H. ...

(b) Address 1314 North & South Rd.

19. (a) MAY 8 - 1940 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1314 North & South Rd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1940 hour 9 minute :00 P.M.

21. I hereby certify that I attended the deceased from 3-22-40  
\_\_\_\_\_ 19\_\_\_\_ to 5-6-40 \_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on 5-6-40 \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis  
ca pancreas

Duration of illness 6 mo.

Due to 46

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

Other conditions arterio-sclerosis  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations enlarged fibrin pancreas  
primary carcinoma  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

707 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. D. ... (M. D. or other) \_\_\_\_\_  
Address Co. ... Date signed \_\_\_\_\_

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

76  
2  
2

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 \_\_\_\_\_

*John M. Meyer*

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *John M. Meyer*

Licensed Embalmer No. *3785*

P. O. Address *340 W. Adams  
Herkewood, Mo.*

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.