

20 JUL 1945

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22761**

Registration District No. **784**

Primary Registration District No. **101**

Registrar's No. **1226**

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 _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **NORMAN ARCHAMBO 125**
(b) If veteran, name war **no**
(c) Social Security No. **488-07-3244**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mrs. Nannie Archambo**
6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **February 12th 1899**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 4 15 hr. min.

9. Birthplace **Flat River Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Machinist & Dye Maker**

11. Industry or business
MOTHER FATHER { 12. Name **Tyman Archambo**
13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Campbell**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Norman Archambo**
(b) Address **830 Elsworth, Ferguson Mo**

17. (a) **Burial** (b) Date thereof **7/1/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park Cem**

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) **JUN 29 1940** (Date received local registrar)
(b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **St. Louis**
(c) City or town **Ferguson**
(If outside city or town limits, write "RURAL")
(d) Street No. **830 Elsworth**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **27th**
year **1940** hour **9** minute **30** P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____.
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**

Due to **Diabetes** $\frac{1}{8}$ yrs

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

PHYSICIAN
Major findings: _____
Of operations **59**
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? **NO** (Specify type of place) Means of injury _____

23. Signature **John O'Connell** (M. D. or other) **5**
Address **Coroner of St. Louis Co.** Date signed **6/28/40**

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

6
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copy

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

John P. Buchholz

Licensed Embalmer No.

16746

P. O. Address

2223 St Louis

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.