

No. 2  
-11-10-30  
5-17-39  
PI X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **23406**  
Registrar's No. **5851**

**AUG 25 1940**  
Registration District No. **791**

Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: St. Joseph of Poplar St.  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(d) Street No. Unknown  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Unknown male Floater  
**8. (c) Social Security** \_\_\_\_\_  
**3. (b) If veteran,** name war \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month June day 30  
year 1940 hour 5:00 minute \_\_\_\_\_ P. M.

**4. Sex** male **5. Color of 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

**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 \_\_\_\_\_

**7. Birth date of deceased:** Unknown  
(Month) (Day) (Year)  
**8. AGE:** About 30 Years Months Days If less than one day  
Unknown hr. min.

Due to Asphyxiation Due to Drowning  
Due to Same place cause and manner could not be ascertained  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**9. Birthplace** Unknown (City, town, or county) (State or foreign country)  
**10. Usual occupation** \_\_\_\_\_  
**11. Industry or business** \_\_\_\_\_  
**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)

**PHYSICIAN** \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**16. (a) Informant** Richard Roy  
**(b) Address** 4230 Louisiana  
**17. (a) Burial** (b) Date thereof 7-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** City Cemetery  
**18. (a) Signature of funeral director** \_\_\_\_\_  
**(b) Address** 3029 Lafayette Ave  
**19. (a) JUL 12 1940** (b) \_\_\_\_\_  
(Date received local registrar) (Date of registration)

**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 work) (e) Means of injury 5  
**23. Signature** Joseph M. ... (M. D. or other)  
**Address** ... Date signed \_\_\_\_\_

**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.

*W. J. Embalsmed*  
Signed \_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**