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No. 2
11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23574**
Registrar's No. **6019**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Cornelius Devine **150**
3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years About 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Missouri **0**
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business _____
12. Name Unknown **9**
13. Birthplace Unknown **7**
(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 Am Morrison
(b) Address Cirt Hospital #1

17. (a) Burial (b) Date thereof July 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette Ave

19. (a) JUL 18 1940 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis **25**
(If outside city or town limits, write "RURAL")
(d) Street No. 905 Market St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 16,
year 1940 hour 1:45 minute A.M.
21. I hereby certify that I attended the deceased from July
11, 19 40 to July 16, 19 40
that I last saw him alive on July 16, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage **5 days**
Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Walter Ford (M. D. or other) _____
Address 1515 Lafayette Date 7/16/40

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

MOTHER FATHER

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 _____

Frank J. Owens

Licensed Embalmer No. 3245

P. O. Address. 1 Mission

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.