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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26329**

Registration District No. **284**

Primary Registration District No. **111**

Registrar's No. **1445**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis County Rich Hill
(c) Name of hospital or institution:
St. Marys 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 John M. Delfosse **412**
8. (b) If veteran, name war world war 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lena Delfosse 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 27 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>2</u>	<u>4</u>	_____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation gardner

11. Industry or business unemployed

MOTHER FATHER
12. Name Emil Delfosse
13. Birthplace Belgium
(City, town, or county) (State or foreign country)
14. Maiden name Adriana Tornfloth
15. Birthplace Europe
(City, town, or county) (State or foreign country)

16. (a) Informant Lena Delfosse
(b) Address 7900a Minnesota

17. (a) burial (b) Date thereof 8/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem. Jeff. Bks

18. (a) Signature of funeral director Fendler Und. Co.

(b) Address 7420 Michigan Ave.

19. (a) AUG 1 1940 (b) Registrar's signature DR. Meyer M.D. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7900a Minnesota
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 31
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from July 25, 1940
_____ 19____ to July 31, 1940
that I last saw him alive on July 31 1940
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Peritonitis
Cholecystitis
Chronic colitis
Due to jejunal ulcer perforate
Jejunocolic fistula
Other conditions Jejunocolic fistula
(Include pregnancy within 3 months of death) and stomach.
PHYSICIAN _____
Major findings: Ulcer in jejunum
Fistula between stomach
transverse colon & jejunum
Of autopsy peritonitis
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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address 508 No. Grand Date signed Aug 1 1940

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

Dr. MAAS
METROPOLITAN BEREAVEMENT
JE 4141
2 P.M.

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.....

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.