

BUREAU OF THE CENSUS  
SEP 25 1940

Registration District No. 791

Primary Registration District No. 1003

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (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 1 week  
 (Specify whether  
 In this community Unknown  
 years, months or days)

8. (a) PRINT FULL NAME Herbert Bishop 21D3. (b) If veteran, name war None 3. (c) Social Security No. None 259-01-91974. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower6. (b) Name of husband or wife Lulu Bishop nee Carter 6. (c) Age of husband or wife if alive Deceased years7. Birth date of deceased November 24, 1884  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
55 8 23 hr. min.9. Birthplace Anna Illinois  
(City, town, or county) (State or foreign country)10. Usual occupation Odd Job work

11. Industry or business

12. Name Lawson Bishop 186013. Birthplace ? Illinois  
(City, town, or county) (State or foreign country)14. Maiden name Harriett Allen15. Birthplace ? Illinois  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Edward Kammerer(b) Address 2127 Switzer Ave17. (a) Burial (b) Date thereof 8/20/40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Friedens Cemetery18. (e) Signature of funeral director Math Hermann & Son(b) Address 2161 East Fair Ave19. (a) AUG 20 1940 (b) [Signature]  
(Date received local registrar) (Signature of registrar)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis City 8  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2127 Switzer Ave  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th  
Year 1940 hour 4:50 AM minute \_\_\_\_\_ 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 Dehydration Duration \_\_\_\_\_of 4th degreeDue to Local PneumoniaDue to suffered in fieldfrom poor to groundMajor findings: Below while workingOf operation about 8442 Laurel StOf autopsy about 110° in lung 9-Accidental

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accidental(b) Date of occurrence 8/17/40(c) Where did injury occur? St. Louis  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place) IndustryWhile at work? Fall  
(Specify type of place) (i) Means of injury23. Signature [Signature] (M. D. or other) \_\_\_\_\_Address [Signature] Date signed \_\_\_\_\_

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**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 William G. Buck

Licensed Embalmer No. 2110

P. O. Address 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27146  
Registrar's No. 7042

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 191

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Herbert Beahap  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 51 Months 8 Days 23 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-4-40 (b) J. F. Budeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS  
(c) City or town JENNINGS  
(If outside city or town limits write "RURAL")  
(d) Street No. 2129 SWITZER AVE  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. Signed by J. M. J. J. J. (M. D. or other) \_\_\_\_\_

Address Deputy Date signed \_\_\_\_\_

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

