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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30318

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 7595

FILED OCT 25 1940

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: 1927 East College Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____

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. 1927 East College Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Dyer

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lulu Dyer

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Aug (Month) 6th (Day) 1888 (Year)

8. AGE: Years 52 Months 1 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Virginia (City, town, or county) (State or foreign country)

10. Usual occupation retired Merchant

11. Industry or business _____

FATHER
12. Name Seldon Dyer
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lillian Tucker
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lulu Dyer
(b) Address 1927 East College Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/40 (Month) (Day) (Year)
(c) Place: burial or cremation St Peters Cemetery

18. (a) Signature of funeral director Stroot - Carroll
(b) Address 4600 Natural Bridge Ave

19. (a) SEP 10 1940 (Date received local registrar) (b) J. J. Breach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9 year 1940 hour 12 minute 15pm M.

21. I hereby certify that I attended the deceased from Aug 20, 1940, to Sept 9, 1940 that I last saw him alive on Sept 9, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis — Duration acute
following Bronchiectasis

Due to Bronchiectasis

Due to Bronchial asthma

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations T.D.b.

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 H. E. Magers (M. D. or other) M.D.

Address 4005 W. Florissant Date signed 9-9-40

(Licensed Embalmer's Statement on Reverse Side)

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 H Stroof

Licensed Embalmer No. 2265

P. O. Address 4600 Natt Bridge av

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.