

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 30834Registration District No. 79Primary Registration District No. 1003Registrar's No. 8111

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:
5010 Durant Avenue
 (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 days8. (a) PRINT FULL NAME Charles Adams8. (b) If veteran,
name war _____8. (c) Social Security
No. 708-16-88744. Sex Male 5. Color or race White
6. (a) Single, widowed, married,
divorced Married6. (b) Name of husband or wife
Josephine Adams 6. (c) Age of husband or wife if
alive 55 years7. Birth date of deceased 7 11 1884
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
56 2 15 hr. _____ min.9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Cabinet Maker11. Industry or business Pullman Co.12. Name Unknown18. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Josephine Adams(b) Address 5010 Durant17. (a) Burial (b) Date thereof 9-30-1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation New St. Marcus Cemetery18. (a) Signature of funeral director Truth Center Mortuary
4024 Lindell Biv'd.19. (a) SEP 30 1940 (b) J. D. Budick
(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. 5010 Durant Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26th
year 1940 hour 1:25 A.M. minute _____ M.21. I hereby certify that I attended the deceased from 5-10-40
_____, 19____, to 9-26-40, 19____;
that I last saw him alive on 9-25-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic myocarditis
Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations none madeOf autopsy none made

Duration

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 H. SporenmanAddress 1506 87L bus Date signed 9-28-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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. 4110

P. O. Address 4024 Lindell St. d

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.