

No. 2
11-10-39
5-17-39
I X21492

FILED NOV 25 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36635

State File No. _____

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 269

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town East Washington Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp # 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mos 18 days 3
(Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis City

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3920 North Market
(If rural, give location)

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

3. (a) PRINT FULL NAME George Wood

8. (b) If veteran, name war: unknown 8. (c) Social Security No. 2500

4. Sex m 6. Color of hair w 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 28
year 1940 hour 10 minute P M.

21. I hereby certify that I attended the deceased from 7-29, 1940, to 10-28, 1940;
that I last saw him alive on 10-28-40, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business _____

12. Name unknown

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace _____
(City, town, or county) (State or foreign country)

Immediate cause of death, Chronic myocarditis with general arterio sclerosis

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underlines the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant Kap # 3 Records

(b) Address Nevada Mo

17. (a) Burial (b) Date thereof 10/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis Mo

18. (a) Signature of funeral director Marshall C. Singer

(b) Address Nevada Mo

19. (a) 10-29-40 (b) Allen
(Date received local registrar) (Registrar's signature)

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

23. Signature Allen (M. D. or other) 10/29/40
Address State Kap # 31 Date signed 10/29/40

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

8

RECEIVED

District Health Officer No. 7,

District File Number 11-40-1236

Date Filed 11-4-40

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

Manki Lechinger

Licensed Embalmer No. 2656

P. O. Address Neveida, Mo

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.