

No. 2  
1-13-40  
-17-39  
X23150

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36843

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 9116

FILED DEC 11 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: St. Peter's 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

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. 2445 Laflin Ave (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME CASPER HENRY FLEER

3. (b) If veteran, name war NO 3. (c) Social Security No. 498-07-8645

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 3 year 1940 hour 12 minutes midnight  
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.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lillie Fleer 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased May 10 1866  
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Watchman

11. Industry or business Stix-Baer-Fuller Ware house

12. Name unknown

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

14. Maiden name Fredricka Beinfeld

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

16. (a) Informant Mrs Henry Fleer

(b) Address 2445 Laflin Ave

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

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director H. Kron & Co.  
(b) Address 2707 N. Grand Blvd.

19. (a) NDV 6 1940 (b) J. B. Brueck  
(Date received local registrar) (Registrar's signature)

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Chronic myocarditis  
Chronic nephritis  
131

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) \_\_\_\_\_ (Specify means of injury)  
23. Signature Alfred Perry (M. D. or other)  
Address 1214 1/2 Cornwell Date signed 11/4/40

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

MOTHER FATHER

**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.....

*Paul F. Inoué*

Licensed Embalmer No.....

2631 -

P. O. Address.....

2707 N. St.

**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, fact should be so stated above.**