

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37462**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **9735**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 55 Mins.
In this community 55 Mins.
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Raby Ahrens

3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Newborn

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

7. Birth date of deceased November 3, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 55 min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name Louis Ahrens

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

14. Maiden name Minette Ahrens

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

16. (a) Informant Ann Morrison

(b) Address City Hospital #1

17. (a) Amation (b) Date thereof 11-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital #1

19. (a) NOV 27 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 24
(If outside city or town limits, write "RURAL")
(d) Street No. 2113 Stansbury
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3
year 1940 hour 6:10 minute P. M.

21. I hereby certify that I attended the deceased from November 3, 1940 to November 3, 1940
that I last saw him alive on November 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

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. Signature [Signature] (M. D. or other)
Address 1515 Lafayette Ave. Date signed 11/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

..... P. O. Address:.....

-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.