

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39738**

Registration District No. **784**

Primary Registration District No. **2nd**

Registrar's No. **2252**

1. PLACE OF DEATH:

(a) County St. Louis
 (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. Rose Sanatorium
 (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) 3

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 29
 year 40 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from
10/28/1940, 1940, to 11/29/1940,
 that I last saw him alive on 11/29/1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Pneumonia Duration 7 weeks

Due to _____
 Due to 73

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy None

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 Lois E. Gerson (M. D. or other)
 Address St. Rose Sanatorium Date signed 11-29-40

8. (a) PRINT FULL NAME STEIN RALPH W.

8. (b) If veteran, name war _____ 8. (c) Social Security No. 488-03-7032

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

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

7. Birth date of deceased JAN. 25 1903
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
37 10 4 hr. _____ min.

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

10. Usual occupation Auditor

11. Industry or business Southwestern Bell Telephone Co.

12. Name William Stein

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

14. Maiden name Agnes Kelley
 (City, town, or county) (State or foreign country)

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

16. (a) Informant William W. Stein

(b) Address Coburg Drive

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Dec 2 1940
 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove M.A.V.S.

18. (a) Signature of funeral director DREHMANN-HARTAL

(b) Address 1905 UNION ST. ST. LOUIS

19. (a) NOV 30 1940 (Date received local registrar) (b) [Signature] (Registrar's signature)

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

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

Robert M. Sanford

Licensed Embalmer No.

2273

P. O. Address _____

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

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