

No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19787**
Registrar's No. **4599**

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Firmin DeLoge Hospital
(d) Length of stay: In hospital or institution 7 weeks
In this community 14 years

3. (a) PRINT FULL NAME Dennison, Charles
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife FLORA 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased May 23 1870

8. AGE: Years 71 Months 0 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Edge Hill, Missouri

10. Usual occupation Night Watchman

11. Industry or business unemployed (10 years)

12. Name John Dennison
13. Birthplace Kentucky
14. Maiden name Liscinda Trollinger
15. Birthplace Missouri

16. (a) Informant Clarence Barbis
(b) Address 2655a California Avenue

17. (a) burial (b) Date thereof June 3, 1941
(c) Place: burial or cremation Lesterville, Missouri

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue

19. (a) JUN 2 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County MOO
(c) City or town St. Louis
(d) Street No. 3437 Henrietta Avenue
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 31 year 41 hour 4 minute 05 P.M.
21. I hereby certify that I attended the deceased from Apr. 14, 1941, to 5-31, 1941; that I last saw him alive on 5-31-41 and that death occurred on the date and hour stated above.

Immediate cause of death: Septicemia - probably Streptococcus
Due to infected leg
Due to Diabetic gangrene of rt leg

Duration 48 hours

Other conditions _____
Major findings: Of operations same
Of autopsy same

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (e) Means of injury fall
23. Signature [Signature] (M. D. or other) _____
Address DeLoge Hospital Date signed _____

6-1-41

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 A Keith

Licensed Embalmer No. 3612

P. O. Address. 2317 Lafayette

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.