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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
LED JAN 24 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40237

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 9971

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:
City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether _____)

In this community 15 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St Louis 25
(If outside city or town limits, write "RURAL")

(d) Street No. 218 So 4th
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Wray

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12
year 41 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h. _____ 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 Single

6. (b) Name of husband or wife _____

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

Immediate cause of death
Chronic Myocarditis
Chronic Interstitial Nephritis
Arteriosclerosis

Due to _____

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

Major findings: Of operations _____

Of autopsy Pending 1316

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

8. AGE: Years about 73 Months Days If less than one day hr. min.

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? _____

(Specify type of place) _____

While at work? _____ (Specify type of place) _____

23. Signature Thomas F. Holland (Physician or other) _____
Address Deputy Coroner Date signed 12/16/41

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

10. Usual occupation laborer

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

15. Birthplace Laurens 6
(City, town, or county) (State or foreign country)

16. (a) Informant P. J. Murta

(b) Address 218 So 4th

17. (a) Burial (b) Date thereof 12-17-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Matthews Cem

18. (a) Signature of funeral director Holloway Funeral Home
Cuba, Mo

(b) Address _____

19. (a) DEC 16 1941 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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.....

John J. Geller

Licensed Embalmer No. 3880

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.