

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15638, 1
State File No.

Registration District No. 754

Primary Registration District No. 200

Registrar's No. 940

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 1/5/42
(Specify whether years, months or days)
In this community Since 1/5/42

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Adams
(c) City or town Quincy
(If outside city or town limits, write "RURAL")
(d) Street No. 1028 Adams Str.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BISHOP, Edward W.

3. (b) If veteran, name war World, 1918
3. (c) Social Security No. Not known

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

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

7. Birth date of deceased: November 7 1892
(Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 19
If less than one day hr. min.

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

10. Usual occupation Stone quarry worker

11. Industry or business Quarrying

MOTHER FATHER

12. Name Tom Bishop

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

14. Maiden name Lena Bunke

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

16. (a) Informant Government Records

(b) Address Vet. Adm. Bldg., Jeff. Bks., Mo.

17. (a) Burial (b) Date thereof 4-28-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quincy, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington St., St. Louis, Mo.

19. (a) 4-27-42 (b) C. H. McDevan, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1942 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from 1/5/42 19... to 4/26/42 19...
that I last saw him alive on 4/26/42 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism.
Duration About 1 hr.

Due to Freezing of hands and feet with secondary gangrene and slough 115 da.

Due to _____

Other conditions (Include pregnancy within 5 months of death) 190 99

Major findings: Of operations No operation

Of autopsy No autopsy

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) Means of injury _____

23. Signature L. M. COCHRAN, M.D. (M. D. or other)
Address Chief Medical Officer Date signed _____

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

96 506

No 0500

[Handwritten initials]

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.....

J. G. Sullivan

Licensed Embalmer No. *1122*

P. O. Address *4704 Washington 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.