

18934

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

JUN 15 1942  
Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1268

1. PLACE OF DEATH: **St. Louis**

(a) County **St. Louis**

(b) City or town **Clayton**

(c) Name of hospital or institution: **St. Louis County Hospital**

(d) Length of stay: In hospital or institution **1 hour**

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**

(c) City or town **S. Kinloch**

(d) Street No. **Carson & Hugo Ave.**

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME **Certain, Baby Boy**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **6**

year **1942** hour **2** minute **05** p. M.

4. Sex **male** 5. Color or race **colored** 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 **June 6 1942**

21. I hereby certify that I attended the deceased from **6-6-42** to **6-6-42**

that I last saw him alive on **6-6-42** and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day **1 hr.** min.

Immediate cause of death **Respiratory failure**

Due to **Permanently** **159** **5 1/2 mo**

Due to \_\_\_\_\_

Other conditions (includes pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace **Clayton Mo.**

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Ira Certain**

13. Birthplace **unknown Miss.**

14. Maiden name **Mary Stockard**

15. Birthplace **Abbyville Mo.**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **John R. ...**

(b) Address \_\_\_\_\_

17. (a) **Cremation** (b) Date thereof **6/10/42**

(c) Place: burial or cremation **City Crematory**

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? \_\_\_\_\_

18. (a) Signature of funeral director **St. Louis Co. Hospital**

(b) Address **St. Louis Co. Hospital**

19. (a) **JUN 10 1942** (b) \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury **D**

Signature **J. R. ...** (M. D. or other) **MD.**

Address **St. Louis Co. Hospital** Date signed **6-9-42**

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

Rev. 5-17-39  
1 x1951

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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, above space should be left blank.**