S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 18 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26445

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7121

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: FAITH HOSP. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 17

(c) City or town ST. LOUIS 8 9
(If outside city or town limits, write "RURAL")

(d) Street No. 529 BITTNER ST
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LEON GERLD ATCHISON

3. (b) If veteran, name war — — —

3. (c) Social Security No.

4. Sex MALE

5. Color or race 0 WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife NELLIE ATCHISON

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased MARCH (Month) 27 (Day) 1885 (Year)

8. AGE: Years 58 Months 4 Days 8 If less than one day hr. min.

9. Birthplace KENTUCKY (City, town, or county) 1 (State or foreign country)

10. Usual occupation MACHINEST

11. Industry or business [illegible]

FATHER
12. Name JOHN LAWSON ATCHISON
13. Birthplace KENTUCKY (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name STACY WOOLFORD
15. Birthplace BLAIR (City, town, or county) ILL 1 (State or foreign country)

16. (a) Informant Mellie Atchison
(b) Address 529 Bittner ST.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 7-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Union Cem. SPARTA ILL

18. (a) Signature of funeral director Friedrich F. HOME
(b) Address 8319 Halls Ferry Rd

19. (a) AUG 6 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4
year 1943 hour 12 minute 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.

	Duration
Immediate cause of death: Carcinoma in transverse colon	
Due to not known	3 mo.
Due to	
Other conditions (Include pregnancy within 3 months of death): none	

Major findings:
Of operations Carcinoma of Colon
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) no
(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? (e) Means of injury 0

23. Signature Dr. H. F. Miller M.D. (Ex. or other)
Address 8410 N. Broadway St Louis Mo Date signed 8/6/43

(Licensed Embalmer's Statement on Reverse Side)

OCT 1 1943

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 Arthur P. Friedrich

Licensed Embalmer No. 3556

P. O. Address St. Louis

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.