

S. No. 2  
M-2-43  
5-17-39  
I X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32184**  
**8773**

LED OCT 19 1943  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis

(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 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 40 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: **1003**

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis **000**  
(If outside city or town limits, write "RURAL") **179**

(d) Street No. 4409 Blair Ave. **9**  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Lillie Hobbs

3. (b) If veteran, name war none

3. (c) Social Security No. 489-07-5893

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1st.  
year 1943 hour 11:50 AM minute \_\_\_\_\_ M.

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Lonnie Hobbs

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased March 2 1902  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Fluoride Poisoning  
Self Administration of Key house  
4409 Blair Ave Oct 1st 1943  
Due to about 4:00 AM

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>6</u>	<u>29</u>	hr. _____ min.

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

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

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

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

9. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Operator

11. Industry or business Mound City Cap Co.

12. Name W. R. Meyers

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

14. Maiden name Omey Burks

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

16. (a) Informant Lonnie Hobbs

(b) Address 4409 Blair Ave.

17. (a) Burial (b) Date thereof 10-5-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Hy. Leidner Und. Co.  
(b) Address 2223 St. Louis Ave

19. (a) OCT 4 1943 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence Oct 1 1943

(c) Where did injury occur? St Louis  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home  
(Specify type of place)

While at work? no (a) Means of injury Fluoride

23. Signature Thomas F Callaway (b) or other \_\_\_\_\_  
Address Deputy Coroner Date signed 10-2-43

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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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 Homer L. Ponder  
Licensed Embalmer No. 3367  
P. O. Address 2523 St. Louis ave

**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.**