

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35826**

**FILLU OCT 23 1943**

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 2346

1. PLACE OF DEATH: St Louis  
 (a) County St Louis  
 (b) City or town KOCH  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Rohit Koch Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 yrs, 4 mo 18 days  
 (Specify whether years, months or days) 6 years

2. USUAL RESIDENCE OF DECEASED: 0000  
 (a) State Missouri (b) County 17  
 (c) City or town St Louis 9  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2605 LAWTON AVE  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PAUL SENTER  
 (also known as PAUL WARE ARMSTEAD)  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. 487-14-3595

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct day 15  
 year 1943 hour 4 minute 45 A.M.

4. Sex M 5. Color or race C  
 6. (a) Single, widowed, married, divorced single  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased MARCH 26 1920  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 27 1941 to Oct 15 1943  
 that I last saw him alive on Oct 15 1943  
 and that death occurred on the date and hour stated above.

8. AGE: Years 23 Months 6 Days 19  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Tuberculosis of the spine Jan '39(?)  
 Duration \_\_\_\_\_

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

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

10. Usual occupation Salesman

Other conditions Ampland Disease  
 (Include pregnancy within 6 months of death)

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

PHYSICIAN \_\_\_\_\_

12. Name Robert Senter

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

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

Of autopsy 16

14. Maiden name Alice Wilson

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

16. (a) Informant Rohit Hospital Record

(b) Address Robert Koch Hosp

17. (a) BURIAL (b) Date thereof 20-20-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jack H. Ferguson

(b) Address 2946 Lawton Blvd  
OCT 20 1943  
 (Date received local registrar)

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)  
 (e) Means of injury \_\_\_\_\_

23. Signature Frank Cohen (M. D. or other)  
 Address Rohit Koch Hosp Date signed 10/16/43

(Licensed Embalmer's Statement on Reverse Side)

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

96  
0  
0

MOTHER FATHER

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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.....

*James G. Lammons*

Licensed Embalmer No.....

*4142*

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.**