

S. No. 2
M-5-43
7-5-17-39
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26027
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5806**
Registrar's No. **1869**

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Harry Temple

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

4. Sex MALE 5. Color or race WHITE 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 UNKNOWN
(Month) (Day) (Year)

8. AGE: Years 46 Months Days If less than one day hr. min.

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

10. Usual occupation OPERATOR

11. Industry or business DRESS

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Dave Weber

(b) Address 812 Washington

17. (a) BURIAL (b) Date thereof 2-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emet

18. (a) Signature of funeral director D. J. ...

(b) Address 4469 W. ...

19. (a) FEB 25 1944 (b) J. F. ...
(Date received local office) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3127 LOCUST
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 23rd
year 1944 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from Feb. 12th
1944, to Feb. 22nd, 1944.
that I last saw him alive on Feb. 22nd, 1944.
and that death occurred on the date and hour stated above.

Immediate cause of death Peripheral circulatory collapse
Duration

Due to acute left ventricular heart failure
pulmonary edema

Due to Malnutrition & Antismiasis
Carcinoma of Bronchus - metastatic

Other conditions C
(Include pregnancy within 3 months of death)

Major findings: Of operations H7
Of 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) (i) Means of injury.....

23. Signature W. J. Wade (M.D. or other) 2/23/44

Address 1515 Lafayette Date signed.....

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. B. Greenhauer

Licensed Embalmer No.....

3609

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, fact should be so stated above.