

No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

23737
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8855
State File No. _____
Registrar's No. 2079

Registration District No. 3-1-8 Primary Registration District No. 1003

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 15 days (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 429 Victor St. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Abner Defir
3. (b) If veteran, name war _____ 3. (c) Social Security No. Unk.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Blanche 6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased November 20th 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 3 15 hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Jim Defir

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

14. Maiden name ?

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Cremation (b) Date thereof 4 30 44
(Barial, cremation, or removal) (Month) (Day) (Year)

(c) Place: City Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital NO. 1

19. (a) MAR 29 1944 (b) J. F. Bussick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 11th
year 1944 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from Feb. 26th
19 44 to March 11th 19 44
that I last saw him alive on March 11th 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Arteriosclerotic heart disease
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
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) _____
(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) (c) Means of injury _____
23. Signature Gray Jackson (M. D. or other) M.D.
Address 1515 Lafayette Date signed 3/13/44

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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, fact should be so stated above.