

No. 2
1-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16516

State File No. _____

FILED JUN 1 1948

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4729

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:
1523 Palm Str
(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 Mo (b) County _____
(c) City or town St Louis MO
(If outside city or town limits, write "RURAL")
(d) Street No. 1523 Palm Str
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME David Albar Lancaster

3. (b) If veteran, name war _____ 3. (c) Social Security No. 381-01-6400

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 3 Divorced
6. (b) Name of husband or wife Not Known 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 11 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 ----- 4 -- 11-6 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

12. Name James A. Lancaster
13. Birthplace Tenn. (City, town, or county) (State or foreign country)
14. Maiden name Magie Johson
15. Birthplace Mississippi (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Altha A. Williams
(b) Address 1523 Palm Str 1944
17. (a) Burial (b) Date thereof May 25 th
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Edward T. Koch
(b) Address 3516 N 14 Th Str

19. (a) MAY 22 1948 (Date received local registrar) J. F. Bredbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from April 28/44 to May 22 1944
that I last saw him alive on May 22 44 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation of Heart
Due to Bright Disease

Other conditions (Include pregnancy within 3 months of death) 130

Duration 4 hrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

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 E. J. Thomas (M. D. or other) _____
Address 155 S Madison Date signed 6/23/44

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

MOTHER FATHER

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 _____

John Ketter

Licensed Embalmer No. 3880

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.