

FILED AUG 28 1944

Registration District No. ....

Primary Registration District No. 3063

Registrar's No. 1766

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

26  
2  
3

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis Co. Hosp  
(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 St. Louis  
(c) City or town Normandy  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7512 St. Charles Rk. Rd  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

ROLAND D. POST

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 S O

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Sept 29 1932  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
11 10 20 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation nil

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

MOTHER FATHER

12. Name Charles E. Post

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

14. Maiden name Drucilla Hockett

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas E Post

(b) Address 7512 St. Charles Rd. Rd.

17. (a) Burial (b) Date thereof 8-23-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director Baumman Bros

(b) Address 2504 Woodson Rd. Overland Mo.

19. (a) AUG 28 1944 (b) C. M. Gavan, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19  
year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of the appendix Duration \_\_\_\_\_

Due to Acute appendicitis

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

Other conditions 17111  
(Include pregnancy within 3 months of death)

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

Of autopsy No (Post mortem examination of cere bro spinal fluid)

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 C. M. Gavan (M. D. or other) M.D.

Address 601 Brentwood Blvd. Date signed 8/22/44

**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 Oscar F. Mueller  
Licensed Embalmer No. 3039  
P. O. Address Overland Mo

**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.**