

No. 2
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X-36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8074**
Registrar's No. **2384**

Registration District No. **318** 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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 mos. 2 days**
In this community **45 years**
(Specify whether 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. **1436 Cole St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charles Myland**
3. (b) If veteran, name war **No**
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **10,**
year **1945** hour **2** minute **05 P.** M.
21. I hereby certify that I attended the deceased from **January**
8, 19 **45** to **March 10,** 19 **45**
that I last saw him **in** alive on **March 10,** 19 **45**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **Col.**
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 **April 10, 1899.**
(Month) (Day) (Year)

Immediate cause of death **Primary Carcinoma of liver**
Duration **Indef.**
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
45 II 0 hr. _____ min.

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace _____
(City, town, or county) (State or foreign country)
10. Usual occupation **Chauffeur**
11. Industry or business _____
12. Name **Charles Myland**
13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace _____
(City, town, or county) (State or foreign country)

MOTHER FATHER
16. (a) Informant **Gertrude Simmons**
(b) Address **1702 Bell Glade**
17. (a) **Burial** (b) Date thereof **Mar. 16, 1945.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park Cemetery**
18. (a) Signature of funeral director: **Wright's Funeral Home**
3100 Easton Ave.
(b) Address _____
19. (a) **MAR 14 1945** (Date received local registrar)
J. F. Budeck (Registrar's signature)

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 **J. F. Murphy** (M. D.)
Address **2601 W. Webster** Date signed **3/14/45**

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

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..... *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard*

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.

Registration District No. 369

Primary Registration District No. 1003

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: _____
(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

3. (a) PRINT FULL NAME Charles Myland

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased April 10 1945
(Month) (Day) (Year)

8. AGE: Years 45 Months 11 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) MAID 30 1945 (Date received local registration) (b) J. F. Brebeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 10 Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

8074