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

#39987

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19096

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5636

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)
In this community 20 years

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. 1616 Franklin
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CHARLES PAGE

3. (b) If veteran, name war unk

3. (c) Social Security No. unk

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 December 19th, ? (Month) (Day) (Year)

8. AGE: Years abt. 80 Months Days If less than one day hr. min.

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

10. Usual occupation unk

11. Industry or business unk

FATHER
12. Name unk
13. Birthplace unk (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unk
15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital #1.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) JUN 28 1945 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd year 1945 hour 3:35 minute P. M.

21. I hereby certify that I attended the deceased from 5/26/45, 19..., to 6/3/45, 19...; that I last saw him alive on 6/3/45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to	
Due to 108	
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 0

23. Signature Aaron Hendin (M. D. or other)
Address 1515 Lafayette Date signed 6/4/45

(Licensed Embalmer's Statement on Reverse Side)

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.