

No. 2  
OM-5-43  
v. 5-17-39  
I X36871

State File No. \_\_\_\_\_

**FILED** JUL 3 1946  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5671**

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

**1. PLACE OF DEATH:**

(a) County St. Louis, Missouri

(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  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 23 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

**3. (a) PRINT FULL NAME** JOHN COLFER

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 Single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: November 5, 1880  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>65</u>	<u>7</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation: Unemployed

11. Industry or business: --

**MOTHER FATHER**

12. Name: Thomas

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

14. Maiden name: Mary

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

16. (a) Informant: R. Nation

(b) Address: City Hospital

17. (a) Anatomical Board  
(Burial, cremation, or removal)

(b) Date thereof: 6-20-46  
(Month) (Day) (Year)

(c) Place: burial or cremation: Washington

18. (a) Signature of funeral director: W. H. ...

(b) Address: 3100 Rutger St

19. (a) JUN 27 1946  
(Date received local registrar)

J. F. Breaker  
(Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000

(c) City or town: St. Louis  
(If outside city or town limits, write "RURAL" \_\_\_\_\_)

(d) Street No. No home  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 18  
year 1946 hour 5:30 minute A M.

21. I hereby certify that I attended the deceased from May 27  
19 46 to June 18, 19 46

that I last saw h. in alive on June 18, 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death: Aspirin toxic failure

Due to: Cholera T.B. far advanced

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? \_\_\_\_\_

23. Signature: Delaney ... (M. D. or other) M.D.  
Address: 1515 Lafayette Ave. Date signed: 10 June

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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.**