

X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 30 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31515**
8110
Registrar's No. _____

Registration District No. **318**

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:
Father Dempseys Hotel
(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
(If outside city or town limits, write "RURAL")

(d) Street No. Father Dempseys Hotel
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME SAMUEL C. ARCHEY

3. (b) If veteran, name war Unknown

3. (c) Social Security No. _____ ?

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Carrie Andesen (Deceased)

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

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 75 ? Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Structural Steel Worker

11. Industry or business _____

MOTHER FATHER {

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Joe Cousins

(b) Address 618 N. Newstead Ave. St. L. Mo.

17. (a) Burial (b) Date thereof Sept. 21, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Hill Cem. St. L. Co.

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Ave. Maplewood, Mo.

19. (a) SEP 20 1946 (b) J. F. Brudeck
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1946 hour 6:30 minute A. M. 9

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 Bangrene of bowel from incarcerated right femoral hernia

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration _____

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 work)
_____ (of Means of injury)

23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed 9/20/46

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

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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 3454

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

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.