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-8-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 28 1946 318**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **42948**  
Registrar's No. **10894**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

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 \_\_\_\_\_  
(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 St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. Coke Hotel - 728 Chestnut  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **EMMETT SEARCE**  
(b) If veteran, World War name war. (c) Social Security No. 1  
4. Sex my 5. Color or race W.  
6. (a) Single, widowed, married, divorced Widow  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 14th  
year 1946 hour 4:40 minute \_\_\_\_\_ P \_\_\_\_\_ M \_\_\_\_\_  
21. I hereby certify that I attended the deceased from 10/14/46  
to Dec. 14th, 1946  
that I last saw him alive on Dec. 14th, 1946  
and that death occurred on the date and hour stated above.

8. AGE: abt. 60  
Years Months Days  
If less than one day  
hr. min.

Immediate cause of death Cerebral haemorrhage  
Due to Hypertensive vascular Disease  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Louisville Ky  
(City, town, or county) (State or foreign country)  
10. Usual occupation Barber

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

11. Industry or business \_\_\_\_\_  
12. Name Widow  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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?

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

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant City Hospital Record  
(b) Address 1515 Lafayette

23. Signature \_\_\_\_\_  
Address 1515 Lafayette Date signed 12/16/46

17. (a) Burial (b) Date thereof 12-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation National Cem

18. (a) Signature of funeral director C. Hoffmeister  
(b) Address 7814 S. Broadway  
19. (a) DEC 19 1946 (b) Registrar's signature J. F. Bredebeck  
(Date received local registrar) (Registrar's signature)

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

MOTHER, FATHER

JAN 23 1947

*Emb Report Cert file*

DEC 19 1946

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.**