

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2483
Registrar's No. 824

FILED #66892
FEB 23 1947
Registration District No. 3 B48

Primary Registration District No. 1003

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 _____ (Specify whether
In this community 25 Years
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. 2611 Hebert St.
(If rural, give location)

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

3. (a) PRINT FULL NAME WILLIAM FLAKE

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-07-4476

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mary Flake 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 7 1 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>6</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER

12. Name William Flake 9

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

14. Maiden name Alice Kruse

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

16. (a) Informant Mrs Mary Flake
(b) Address 2611 Hebert St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-47
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Goodhart & Goodhart
(b) Address 2228 St. Louis Ave.

19. (a) JAN 24 1947 (Date received local registrar) (b) J. J. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23rd
year 1947 hour 8:20 minute A M.

21. I hereby certify that I attended the deceased from 1/8/47
_____ 19, to 1/23/47 19;
that I last saw him alive on 1/23/47 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Pulmonary Tuberculosis for advanced

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? _____

23. Signature Warren C. Lewis M.D. (Specify type of place) _____
1515 Lafayette (a) Means of injury _____
Date signed 1/23/47 (b) _____

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

Henry M. Brammer

Licensed Embalmer No.....

4200

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.