

No. 2
-12-45
-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5972**
Registrar's No. **2024**

FILED MAR 11 1947

Registration District No. **318**

Primary Registration District No. **100**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo.

(c) Name of hospital or institution St. Louis City Hospital
Max C. Starkloff Memorial

(d) Length of stay: In hospital or institution 24 days

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis

(d) Street No. 2213 S. 2nd St.

(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME: TIMMONS AUSTIN

3. (b) If veteran, name war. ---

3. (c) Social Security No. ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 21
year 1947 hour 12:50 minute P M.

21. I hereby certify that I attended the deceased from January 26, 1947, to February 21, 1947.

that I last saw h. im alive on February 21, 1947, and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: February 4th, ?

Immediate cause of death Coronary Insufficiency

Due to arteriosclerotic heart disease

8. AGE:	Years	Months	Days	If less than one day
<u>abt - 65</u>				hr. _____ min. _____

Due to Chronic glomerular nephritis

Other conditions: Chronic glomerular nephritis

Major findings:
Of operations _____
Of autopsy None

9. Birthplace Ky.

10. Usual occupation ?

11. Industry or business _____

MOTHER FATHER

12. Name Jim Austin

13. Birthplace Unknown

14. Maiden name Mary Raley

15. Birthplace Unknown

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) _____

(c) Place: burial or cremation burial

23. Signature Herbert Sweet (M. D. or other) _____

Address 1515 Lafayette Ave. Date signed 2/21/47

18. (a) Anatomical Board

(b) Address 3500 Fulton St

19. (a) FEB 27 1947 (Date received local registrar)

J. J. Presch (Registrar's signature)

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

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.