

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 months**
 In this community **life**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL.")
 (d) Street No. **7064 Pershing**
(If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Chester W. Pomeroy**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **M.** 5. Color or race **W.** 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 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 80 hr. min.

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

10. Usual occupation **Architect**

11. Industry or business.....

MOTHER FATHER { 12. Name **Chester W. Pomeroy**

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

14. Maiden name **Amelia Smith**

15. Birthplace **N. Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. R. C. Nisbet**
 (b) Address **Steamboat Springs, Colo.**

17. (a) **burial** (b) Date thereof **4-1-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine**

18. (a) Signature of funeral director **Alexander Sone**
 (b) Address **6175 Delmar**

19. (a) **APR 1 1947** (b) **J. J. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **29**
 year **1947** hour **11:** minute **00** P. M.

21. I hereby certify that I attended the deceased from **9-27-47** 19 to **3-29-47** 19;
 that I last saw him alive on **3-29-47** 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis Terminal** Duration

Due to **Posttubercular**

Due to **bronchopneumonia, bilateral, and pulmonary embolism**

Other conditions (Include pregnancy within 3 months of death) **107**

Major findings: Of operations..... **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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?
 While at work? (Specify type of place) (c) Means of injury.....

23. Signature **R. C. Nisbet** (M. D. or other) **3/29-47**
 Address **4932 W. Grand** Date signed.....

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

R. H.
Dr. Friedrichs.
4937 91st Ave. S.W.
Rd. 4620

1-10-11
1-10-10
1-10-08

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 Thomas R. Fenwick
Licensed Embalmer No. 3793
P. O. Address 6175 Helman

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Wm 1403*
3454
Registrar's No. *3454*

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *St Louis*
(b) City or town *St Louis*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME *Chester Pomroy*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *male* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *div*

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

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

8. AGE: Years *abt 80* Months _____ Days _____ (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *4-9-48* (Date received local registrar) (b) *J. F. Pre...* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar* 19*48* year *1948* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;

that I last saw him _____ alive on _____ 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to *General atherosclerosis*

Arteriosclerosis

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 place)

(e) Means of injury _____

Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

