

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36609

FILED OCT 20 1947

State File No. _____

Registration District No. 347

Primary Registration District No. 6076

Registrar's No. 2765

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jennings.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Elms Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 months.
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Florissant
(If outside city or town limits, write "RURAL")

(d) Street No. Route 10 Box 1001
(If rural, give location)

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

3. (a) PRINT FULL NAME Joseph F. Daniels.

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9th.
year 1947 hour 4 minute P.M. M.

21. I hereby certify that I attended the deceased from 5-7-1946
21 19____ to 10-9 1947
that I last saw him alive on 10-8 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, Widowed

6. (b) Name of husband or wife Josephine Daniels. 6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased May 20, 1865.
(Month) (Day) (Year)

Immediate cause of death Pneumonia Duration 3 days

Due to Chronic myocarditis 8 yrs

Chronic nephritis 10 yrs

Due to Arteriosclerosis 28 yrs

8. AGE: Years Months Days If less than one day

82 4 19 hr. min.

Other conditions 1312
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

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

9. Birthplace England. 4
(City, town, or county) (State or foreign country)

10. Usual occupation retired Farmer.

11. Industry or business _____

MOTHER FATHER { 12. Name Dont know. 7

13. Birthplace Dont know. 7
(City, town, or county) (State or foreign country)

14. Maiden name Dont know.

15. Birthplace Dont know. 7
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Arthur J. Daniels.

(b) Address Route 2 Box 59 Florissant, Mo.

17. (a) Burial (b) Date thereof 10-13-1947.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Black Jack Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) 10-16-47 (b) Paul E. Johnson
(Date received local registrar) (Registrar's signature)

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) 0
(e) Means of injury _____

23. Signature M. D. Johnson (M. D. or other) MD
Address Ferguson Mo Date signed 10-20-47

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Mitchell Johnson.
40 s. Florissant Road.
Hours 1 to 2 P.M.
Telephone Atwater 430

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

Clement M. May

Licensed Embalmer No.

3737

P. O. Address

St. Louis

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.