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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38704

FILED NOV 24 1948

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9826**

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether
In this community 8 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1130 Rutger
Memorial (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MICHAEL (J.) TOWNSLEY

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

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 November 2 - 1948
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Homer Townsley
13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy Smith
15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Homer Townsley
(b) Address 1130 Rutger

17. (a) Burial (b) Date thereof 11-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 1130 Rutger Ave

19. (a) NOV 22 1948 (b) J. B. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10th
year 1948 hour 4 minute 50 P M.

21. I hereby certify that I attended the deceased from 11/2/48
to Nov. 10th 19 48
that I last saw h im alive on Nov. 10th 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Septic Duration 28h.

Due to _____
Due to _____

Other conditions Premature infant
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Not yet known

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 1

23. Signature V.H. Pedersen, M.D. 11/11/48 (other)
Address _____ Date signed _____

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.

[Handwritten Signature]

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.