No. 300
—10-47
5-17-39
P I 3906

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

FEDERAL SECURITY AGENCY #41909
National Office of Vital Statistics

FILED DEC 23 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 41874

Registrar's No. 16731

1. PLACE OF DEATH:

(a) County

(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 3 weeks (Specify whether years, months or days)

In this community 30 years

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. 2 Chouteau Avenue
Memorial (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JOHN TANT

3. (b) If veteran, name war Nil

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Sarah

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

7. Birth date of deceased June 30, 1872 (Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 10 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Water Division. City of St. Louis

FATHER
12. Name Lee Tant
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Irvin L. Tant
(b) Address 1317 So. 6th Street

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue

19. (a) DEC 12 1948 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10th year 1948 hour 2 minute 02 P.M.

21. I hereby certify that I attended the deceased from 11/20/48, 19..., to Dec. 10th, 1948 that I last saw him alive on Dec. 10th, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Coll Secondary to [illegible]

Due to

Due to

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M.D. or coroner) 12/10/48

Address 1515 Lafayette Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....D. W. Cooper.....

Licensed Embalmer No.....3830.....

P. O. Address.....2301 Lafayette.....

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.

S. No. 2B
0—4-25-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 10731

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (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 years, months or days) In this community

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

3. (a) PRINT FULL NAME John Tant

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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 (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 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) 1-28-49 (Date received local registrar) (b) J. B. Lacater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 10, 1948 day year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death RETICULUM CELL SARCOMA OF THE	NECK
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

55

Major findings:
Of operations

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

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5. No. 300
v., 10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. #4827

BIRTH NO. _____ REG. DIST. NO. 319 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Faust c. (Last)
4. DATE OF DEATH (Month) Dec (Day) 18 (Year) 1948
5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid
8. DATE OF BIRTH
9. AGE (In years last birthday) If under 1 year: Months Days If under 1 day: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) RETICULUM CELL SARCOMA WITH METASTASIS IN

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* 1941

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE James J. McDonnell (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

SUPPLEMENTARY

(52)-41874