S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 17 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43057

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10349

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. ~~St. Louis~~ (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 919 a Warren St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Cooper E. Vance

3. (b) If veteran, name war WW1
3. (c) Social Security No. 355 05 3324

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Grace Vance
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased January (Month) 3 (Day) 1896 (Year)
8. AGE: Years 50 Months 10 Days 29 If less than one day hr. min.
9. Birthplace Fredericktown (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Vance
13. Birthplace (City, town, or county) Mo. (State or foreign country)

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

16. (a) Informant Grace Vance
(b) Address 919 a Warren St/
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation National Cem.
18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
(b) Address 7814 S. Broadway
19. (a) DEC 4 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2 year 1946 hour 10 minute 35 a 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.
Immediate cause of death Surgical Shock during operation at City Hospital for excising left lung on Dec. 2nd 1946 about 10:35 a.m. Duration
Due to
Due to Operation for abscess of lung
Cause of abscess not known
Other conditions (Include pregnancy within 3 months of death)
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 [signature] (M. D. or other)
Address Date signed 12/4/46

(Licensed Embalmer's Statement on Reverse Side)

Coroners Office.

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 Harry J. Lohmacher

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

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.