

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SEP 10 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29465

Do not use this space.

1. PLACE OF DEATH **Homer G Phillips Hospital** **791**
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... **1003**
 (c) City **St. Louis** (d) Street No. **2601** **N Whittier** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **75** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **8098**

2. PRINT FULL NAME **Mary Bordeaux**
 (a) Residence, No. **2520 N Whittier** St. **11** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **David L Bordeaux**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 6, 1862**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 **75** **3** **20**
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housework**
 9. Industry or business in which work was done, as saw mill, bank, etc. **at home**
 10. Date deceased last worked at this occupation (month and year) **August, 1937** 11. Total time (years) spent in this occupation **Unk.**
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Missouri**

FATHER 13. NAME **William Roberts**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

MOTHER 15. MAIDEN NAME **Sally Harris**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

17. INFORMANT (ADDRESS) **2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cemetery** DATE **Aug 30, 1937**

19. FUNERAL DIRECTOR (ADDRESS) **Charles G. Bates**
4107 Finney Avenue

20. FILED **AUG 28 1937** **J. A. Brebeck**
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **August 26**, 19**37**
 22. I HEREBY CERTIFY, That I attended deceased from **August 18**, 19**37**, to **August 26**, 19**37**
 I last saw her alive on **August 26**, 19**37** Death is said to have occurred on the date stated above, at **2:05** m. **p.m.**
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage

Date of onset

8/18/37**37**

Other contributory causes of importance:

Hypostatic pneumonia**Bronchial**

Name of operation..... Date of.....
 What test confirmed diagnosis? **clinical**. Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify..... (Signed) **L. Lewis**, M. D.
 (Address) **2601 N Whittier**

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed Amelia Dunson

Licensed Embalmer No. 3522

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.)