

SEP 10 1937

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

29553
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1008**
 (c) City **ST. LOUIS MO.** (d) Street No. **3429 EADS AV.** Registered No. **8186**
 (e) Length of residence in city or town where death occurred **56** yrs. - mos. - ds. (f) How long in U. S., if of foreign birth? **56** yrs. - mos. - ds.

2. PRINT FULL NAME

MARY JOERDER.
 (a) Residence, No. **3429 EADS AV.** St. **17** (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **FEMALE**
 4. COLOR OR RACE **WHITE**
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **MARRIED**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **CHARLES JOERDER**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **UNK. 1869**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
ABOUT 68 - -

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. **HOUSEWIFE**
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**

13. NAME **UNKNOWN FOY**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND.**

15. MAIDEN NAME **UNKNOWN**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**

17. INFORMANT **CHARLES JOERDER,**
 (ADDRESS) **3429 EADS AV.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY CEM.** DATE **SEPT 1, 1937**

19. FUNERAL DIRECTOR **E. J. Schurr**
 (ADDRESS) **3125 Lafayette Ave.**

20. FILED **AUG 31 1937** 19 **J. S. Dedek**
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Aug 29 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Aug** 19..... to..... 19.....
 I last saw him alive on **Aug 29 1937** Death is said to have occurred on the date stated above, at **A. 10 P. M.**
 The principal cause of death and related causes of importance were as follows:

Cerebral Haemorrhage Date of onset **8/21/37**

Other contributory causes of importance:

arteriosclerosis
broncho pneumonia 1935 8/29/37

Name of operation **None** 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? **No**
 If so, specify.....
 (Signed) **E. G. O'Brien**, M. D.
 (Address) **2815 Park Ave.**

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

899

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STATEMENT BY LICENSED EMBALMER

I, James G Sullivan, Licensed Embalmer No. 2260
hereby certify that the body recorded on the reverse side of this certificate was embalmed by James G Sullivan
.....L. E.
No. or by Registered Apprentice No.
working under my personal supervision.
Signed James G Sullivan
Licensed Embalmer No.

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.)