

NOV 15 1937

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

35666
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St Louis** (d) Street No. **2218** **1003** mar 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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **3973 Ferry Ave** St. **11**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **col** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mary Jarrey**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Dec 25 1887**

7. AGE YEARS **49** MONTHS **9** DAYS **3** If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Plaster & Building Cont.**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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) **Lexington Miss**

FATHER 13. NAME **Pete Torrey**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Lexington Miss**

MOTHER 15. MAIDEN NAME **unknown**

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

17. INFORMANT **Mary Jarrey** (ADDRESS) **3973 Ferry Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **10-2-37**

19. FUNERAL DIRECTOR **W. Budzicki** (ADDRESS) **2707 Stoddard St**

20. FILED **OCT 2 1937** **J. Budzicki** Local Registrar.

NO PHYSICIAN IN ATTENDANCE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-28** 19**37**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at **7:40 A.M.**

The principal cause of death and related causes of importance were as follows:

Pachy Meningitis.
Oedema of the Brain.

Date of onset

Other contributory causes of importance:

Name of operation **79a** Date of.....
 What test confirmed diagnosis? Was there an autopsy? **Yes**

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) **Joseph M. Quinn** M.D.
 Address **Deputy Coroner**

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.

215-22

STATEMENT BY LICENSED EMBALMER

I, Arthur L. Heilbard, Licensed Embalmer No. 3389

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

Arthur L. Heilbard

Licensed Embalmer No. 3389

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.)