

NOV 15 1937

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

36063  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **1003**  
(b) Township..... Primary Registration District No. **City Hospital No. 1**  
(c) City **St. Louis,** (d) Street No. **4334 Manchester** St. **18**  
(e) Length of residence in city or town where death occurred yrs. mos. ds. **10** How long in U. S., if of foreign birth? yrs. mos. ds. **C. 1688**

Registered No. **9640**

2. PRINT FULL NAME

(a) Residence, No. **4334 Manchester** St. **18** (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 **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov 2, - 1917**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
**19** **11** **12**

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. **nil**  
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) **Indiana**

13. NAME **Rose Schnarr**

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

15. MAIDEN NAME **Myrtle Morgan**

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

17. INFORMANT **Hosp. Info M. Kent** (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **Sunset Burial Park** DATE **Oct 16** 19**37**

19. FUNERAL DIRECTOR **Edith E. Ambuster** (ADDRESS) **4334 Manchester**

20. FILED **OCT 16 1937** **J. Bredek** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10/14/37**, 19

22. I HEREBY CERTIFY, That I attended deceased from **5/5/37** 19 to **10/14/37** 19.

I last saw him alive on **10/14/37** 19. Death is said to have occurred on the date stated above, at **4.40 p**

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

*Pulmonary tuberculosis*

Date of onset

Other contributory causes of importance: **23**

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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) **E. P. Ref.**, M. D.

(Address) **City Hospital No. 1**

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.

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**STATEMENT BY LICENSED EMBALMER**

I, ..... Licensed Embalmer No. ....

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

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed.....

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.)**