

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

36066
Do not use this space.

1. PLACE OF DEATH

(a) County **NOV 15 1937**
(b) Township
(c) City **St. Louis**

791
1008
Registered No. **9643**

Registration District No. _____
Primary Registration District No. **1**
(d) Street No. **City Hospital No. 1** 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.
C. 8932

2. PRINT FULL NAME

(a) Residence, No. **Mabel Zeiser**
806 2 North 9th st. 23 (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 **femalee** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Divorced**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **divorced (unknown)**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 24, 1892**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 10 **6** **24**
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **hwk**
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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10/15/37**
22. I HEREBY CERTIFY, That I attended deceased from **9/19/37**, 19____, to **10/15/37**, 19____
last saw her alive on **10/15/37**, 19____ Death is said to have occurred on the date stated above, at **7 p. m.**
The principal cause of death and related causes of importance were as follows:

*Carcinoma of ovaries with metastases
chronic Pelvic Inflammation*
Other contributory causes of importance:
*Suppurative nephritis
arteriosclerosis general
C. N. S. Syphilis - Tabes dorsalis*

Date of onset
49A

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Arkansas**
13. NAME **Unknown**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **"**
15. MAIDEN NAME **Unknown**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **"**

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **ya.**

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. R. H.**, M. D.
(Address) **City Hospital No. 1**

17. INFORMANT **Hosp. Info M. Kent** (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE **Lake Charles** DATE **10/18/37**
19. FUNERAL DIRECTOR **Chas. A. Bull** (ADDRESS) **4452 Washington St.**
20. FILED **OCT 17 1937** **J. J. Predeck** Local Registrar

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.

877
2
31
31

STATEMENT BY LICENSED EMBALMER

I, Howard F Rowland, Licensed Embalmer No. 3114

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

L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed Howard F Rowland

Licensed Embalmer No. 3114

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.)