

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

39345

Do not use this space.

1. PLACE OF DEATH **DEC 12 1937**

791

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. **1003** Registered No. **10332**  
(c) City **St. Louis, Mo.** (d) Street No. **5020 Wabada Ave.,** 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. moe. da.

2. PRINT FULL NAME **Lillie G. Holt,**  
(a) Residence, No. **5020 Wabada Ave.,** St. **6**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov 5 1937**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **George J. Holt,**

22. I HEREBY CERTIFY, That I attended deceased from **Nov 1 1937** to **Nov 5 1937**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 23rd, 1885**

I last saw h. **et** alive on **Nov 5 1937** Death is said to have occurred on the date stated above, at **1230 A.M.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
**30 52 4 12**

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

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. ....  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

**Chronic Myocarditis with Atrial fibrillation** Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

Other contributory causes of importance: **ABC virus**

13. NAME **Frederick Michael,**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

15. MAIDEN NAME **Not known**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

17. INFORMANT (ADDRESS) **George J. Holt, 5020 Wabada Ave.,**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Oak Grove** DATE **Nov. 8th 1937**

19. FUNERAL DIRECTOR (ADDRESS) **My Friend Mnd. Co. 14170<sup>th</sup> Market Street.**

20. FILE NO. **NOV 7 1937** **J. K. Bredeck** Local Registrar.

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

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 **Chas Hagl Physician, M.D.**  
(Signed) **Humboldt Rd.**  
(Address) .....

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.

AUG 18 1944

**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.....

*Al. H. Sedler*

Licensed Embalmer No.....

2256

**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.)**