

JAN 10 1938

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

43805
Do not use this space.

291
1003

Registered No. 12055

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City St. Louis (d) Street No. Homer G. Phillips Hosp. 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

Gudes
(a) Residence, No. 1104 N. 19th St. St. 25
(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 F 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) -

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-13-1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 2 hrs. or min. 2 hrs.

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

12. BIRTHPLACE (CITY OR TOWN) St. Louis 1
(STATE OR COUNTRY) Mo.

13. NAME Payton Gudes 2

14. BIRTHPLACE (CITY OR TOWN) Tenn. 2
(STATE OR COUNTRY)

15. MAIDEN NAME Iola Mitchell

16. BIRTHPLACE (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

17. INFORMANT Father Maynard
(ADDRESS) 2601 N. Whittier

18. BURIAL, CREMATION, OR REMOVAL CITY CEMETERY DEC 30 1937

19. FUNERAL DIRECTOR W. Hamilton
(ADDRESS) City Health Dept

20. FILED DEC 29 1937 J. F. Brudeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-13- 19 37

22. I HEREBY CERTIFY, That I attended deceased from 12-13- 19 37 to 12-13- 19 37

I last saw her alive on 12-13- 19 37. Death is said to have occurred on the date stated above, at 3:52 a. m.
The principal cause of death and related causes of importance were as follows:

Asphyxia of new born
Prematurity
159
Date of onset

Other contributory causes of importance:

Name of operation..... 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?.....
If so, specify.....
(Signed) H. C. Spornell M. D.
(Address) 119 Phillips Hosp.

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.)