

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

337
Do not use this space.

FEB 12 1938

791
1003

Registered No. **193**

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis (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. 13984
 2. PRINT FULL NAME Addie Merrill MERRILL 1040
 (a) Residence, No. 5023 Washington St. **12** (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) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 27, 1860

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/5/38, 19
 22. I HEREBY CERTIFY That I attended deceased from 12/24/37 to 1/5/38, 19.
 I last saw her alive on 1/5/38, 19. Death is said to have occurred on the date stated above, at 3.05 p.m.
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 5 8
 OCCUPATION 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

Cerebral Thrombosis
§ 26
 Other contributory causes of importance:
Genes. ather. arteriosclerosis
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Connecticut

FATHER 13. NAME unknown

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent
City Hospital

Name of operation..... 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.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Lebanon Cemetery Jan. 7th, 1938

Manner of injury.....
 Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS) C. R. Lupton & Sons.
4449 Olive, St.

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) Chas. M. Jessing, M. D.
 (Address) City Hospital No.

20. FILED JAN 6 1938, 19 J. F. Bredeck
 Local Registrar.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

STATEMENT BY LICENSED EMBALMER

I, C. R. Lupton, Licensed Embalmer No. # 2123
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Clarence H. Murray
L. E.
No. 4011 or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed C. R. Lupton
Licensed Embalmer No. 2123

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)