

FEB 16 1938

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

4096  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 96  
 (b) City St. Louis, Mo. Primary Registration District No. \_\_\_\_\_ Registered No. 91  
 (c) City St. Louis, Mo. (d) Street No. St. Mary's Hospital 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 Edith Latimer 856

(a) Residence, No. 3852 Bamberger St.  (Uaual 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  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Latimer  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 7 10 1887  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
50 5 4

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 14 1938  
 22. I HEREBY CERTIFY, that I attended deceased from Jan 5 1938 to Jan 14 1938  
 I last saw h. or alive on Jan 14 1938 Death is said to have occurred on the date stated above, at 6:10 A.M.  
 The principal cause of death and related causes of importance were as follows:

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

Date of onset  
Pneumonia  
390

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lincoln, Nebraska

Other contributory causes of importance:  
Chronic pelvic infection

FATHER 13. NAME James Elting  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

Name of operation Total hysterectomy Date of Jan 6 1938  
 What test confirmed diagnosis? Operation Was there an autopsy? no

MOTHER 15. MAIDEN NAME Jennie Covert  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

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.

17. INFORMANT John Latimer  
 (ADDRESS)

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Sunset Burial DATE Jan 17 1938

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) William H. West M. D.

19. FUNERAL DIRECTOR A. J. ...  
 (ADDRESS) 12707 ...

(Address) 330 ...

20. FILED 1-14-38

139B

STATEMENT BY LICENSED EMBALMER

I, Paul Knollenberg, Licensed Embalmer No. 2631

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

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Paul F. Knollenberg

Licensed Embalmer No. 2631

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

4096 *f*  
Do not use this space.

1. PLACE OF DEATH

(a) County *St. Louis* Registration District No. *784*  
(b) Township *Richmond Hts* Primary Registration District No. *111* Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

*Edith Latimer*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *m*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
*50* *5* *4*

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) (STATE OR COUNTRY)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED *1-14*, 19\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 14*, 19*38*

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

*Peritonitis*

Date of onset

Other contributory causes of importance:

*Chronic Pelvic infection (no evidence of G. C. Cause unknown Total Hysterectomy for Pelvic infection)*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? *(no autopsy)* 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 \_\_\_\_\_

(Signed) *William H. Vest*, M. D.

(Address) *330 Metropolitan Bldg.*

SUPPLEMENTARY

1938  
S-4096