

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

9279
 Do not use this space.

REC'D APR 11 1938

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003** Registered No. **2868**
 (c) City **St Louis Mo** (d) Street No. **City Hospital #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, **20** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Edna West, 290
 (a) Residence, No. **4545^a Aldine** St. **11** (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 **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 **James West**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **January 27th, 1885**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 1 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **none**
 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) **Louisiana Mo**

FATHER 13. NAME **Dane Wade**

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

MOTHER 15. MAIDEN NAME **Elizabeth Sommers**

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

17. INFORMANT (ADDRESS) **Delos C. West, 4545^a Aldine**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Coulterville, Ill.** DATE **3-28-38**

19. FUNERAL DIRECTOR (ADDRESS) **Mullen Bros, 4258 Lindell**

20. FILED **MAR 27 1938** **J. P. Bredich, Local Registrar**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mar 24th, 1938**

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 **11:00** a.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
Apoplexy
 Date of onset
 Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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 **Joseph M. Quinn, M.D., Deputy Coroner**
 (Signed)..... (Address).....

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X12004

STATEMENT BY LICENSED EMBALMER

Thomas P. Fenwick

Licensed Embalmer No.

3793

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

Thomas P. Fenwick

Licensed Embalmer No.

3793

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.)