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.

REC'D MAY 10 1938

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

12892
Do not use this space.

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St Louis Mo
Registration District No. 791
Primary Registration District No. 1003
Registered No. 3496
(d) Street No. BARNES 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 Estella Martin 635
(a) Residence, No. 2905 Delmar St. 21
(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 Col.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Singel
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 29, 1889
7. AGE YEARS 49 MONTHS 2 DAYS 12 If LESS than 1 day, ...hrs. or ....min.

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. Hovis, Work,
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) Mo. 0

FATHER
13. NAME John Fray 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 0

MOTHER
15. MAIDEN NAME Elibeth Houser
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Robert Martin 2305 Dickson Street
18. BURIAL, CREMATION, OR REMOVAL
PLACE Father Dickson Cem. DATE April 14 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mr. F. A. Green 2915 Franklin Avenue
20. FILED APR 14 1938 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-11, 1938

22. I HEREBY CERTIFY, That I attended deceased from 3-15, 1938, to 4-11, 1938
I last saw her alive on 4-11, 1938 Death is said to have occurred on the date stated above, at 1:50 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral embolism	4-11-38
Other contributory causes of importance:	
Carcinoma oesophagus	Few mos.

Name of operation ① Thorocostomy ② X-ray open wound Date of ① 3-31-38 ② 4-6-38
What test confirmed diagnosis? Biopsy 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.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) F R Bradley, M. D.
(Address) BARNES HOSPITAL

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, F. A. Green

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address St. Louis Mo.

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.)

If this body is not embalmed, above space should be left blank.