

REC'D MAY 10 1938

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

12953
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ida Prater 636
 (a) Residence, No. **808 South 2nd** St. **23** (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 Fem.	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 Wife of Charles		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1/15/1907		
7. AGE YEARS 31	MONTHS 2	DAYS 29
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hwf.		
9. Industry or business in which work was done, as saw mill, bank, etc. At Home		
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.		
13. NAME Henry Jones		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.		
15. MAIDEN NAME Ollie Walker		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.		
17. INFORMANT Hosp. info. M. Williams (ADDRESS) City Hospital #1		
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Matthews DATE Apr. 16, 1938		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edw. McLaughlin 2301 Lafayette		
20. FILED APR 18 1938 J. D. Buckner Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4/14/38**, 19...

22. I, HEREBY CERTIFY, That I attended deceased from **4/1/38** to **4/14/38**, 19...
 I last saw h. **im** alive on **4/14/38**, 19... Death is said to have occurred on the date stated above, at **7:50** **A.** M.
 The principal cause of death and related causes of importance were as follows:
Cholelithiasis
Appendicitis, chronic
Localized peritonitis

Other contributory causes of importance:
IP

Name of operation **cholecystectomy & appendectomy** Date of operation.....
 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 **David Steiner**, M. D.
 (Signed) **David Steiner**
 (Address) **1515 Lafayette**

Licensed Embalmer's Statement on Reverse Side)

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.

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,

L.R. Casper

or by

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

Signed

L.R. Casper

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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.