

REC'D JUN 9 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1938

16625
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No.
 (b) Township St. Louis, Mo. Primary Registration District No. Registered No. 4486
 (c) City St. Louis, Mo. (d) Street No. Park Lane 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Benjamin Jefferies Jr. St. Florsissant, Mo.
 (Usual 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 8, 1938
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 0 0 6
 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 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-14-1938
 22. I HEREBY CERTIFY, That I attended deceased from 5-8-1938, to 5-14-1938
 I last saw him alive on 5-14-1938. Death is said to have occurred on the date stated above, at 1:30 P.M.
 The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.
 13. NAME Benjamin Jefferies
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fredricks town Mo.
 15. MAIDEN NAME Lillian Ann Brown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kent Ohio
 17. INFORMANT (ADDRESS) Dr. R. G. Compton 6122 Park Blvd.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Lake Charles Ave DATE 5-15-38
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe 429 N. Euclid Ave.
 20. FILED J. B. Bricker Local Registrar

Bronchopneumonia
 Date of onset _____
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 Other contributory causes of importance:
Premature Birth by Caesarian section
 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.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) R. G. Compton M. D.
 (Address) 6122 Park Blvd

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,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Guy W. Wilkin

Licensed Embalmer No.

3575

P. O. Address

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.