REC'D JUL 7 1938

JUN 12 1938

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

22937
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis
(b) Township
(c) City ~~St Louis County~~ Rich Hgts
(d) Street No. St Marys Hospt 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.

Registration District No. 784
Primary Registration District No. 119
Registered No. 1009

2. PRINT FULL NAME James Lawrence Kidd 300
(a) Residence, No. Desloge Mo. St. Desloge 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

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April I4 I938

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

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
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) Desloge Mo

FATHER
13. NAME James Kidd
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Desloge Mo

MOTHER
15. MAIDEN NAME Leona Griminger
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Desloge Mo.

17. INFORMANT (ADDRESS) James Kidd Desloge Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Desloge Mo. DATE 6-Io 38, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Boyer Desloge Mo.

20. FILED 6-12, 1938 T. R. Meyer M. D. D. P. H. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9 I938, 19

22. I HEREBY CERTIFY, That I attended deceased from June 7, 1938, to June 9, 1938
I last saw him alive on 6/9/38, 19 Death is said to have occurred on the date stated above, at 2:45 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Streptococci meningitis	5/30/38?

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Cysternal puncture 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 No
(Signed) Dr. C. K. Hamilton, M. D.
(Address) St. Marys Hospital

(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.

79w

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 Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp. with the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

22937-
Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis Registration District No. 784
(b) Township Primary Registration District No. 111 Registered No. 1009
(c) City Richmond Hts (d) Street No. St. Mary's Hosp 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 James L. Kidd
(a) Residence, No. Berlage Mo St.
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S-

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

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

7. AGE: Years —; Months 1; Days 25; 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.
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 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9 1935

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:

Streptococcic meningitis (non-epidemic)

Date of onset

Other contributory causes of importance: T.B.

Name of operation Date of
What test confirmed diagnosis? 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) C. Hamilton, M. D.
(Address) St. Mary's Hosp

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE COMPLETED AS PRESCRIBED BY LAW.

AGE should be stated EXACTLY. PHYSICIAN should state classified. Exact statement of OCCUPATION is very important.

CAUSE