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 NOV 16 1938

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

791

34204
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 9190

(c) City St. Louis (d) Street No. City Hospital St.

D. 6617 (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.

D. 1512 South 8th

2. PRINT FULL NAME 550 Betty Jones

(a) Residence, No. 1512 South 8th 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: 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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May 2, 1861

7. AGE: 77 YEARS | MONTHS: 5 | DAYS: 17 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME
9. Industry or business in which work was done, as saw mill, bank, etc. ~~nil~~
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): Missouri 0

FATHER

13. NAME: William Winters
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri 0

MOTHER

15. MAIDEN NAME: Jane Band
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri 0

17. INFORMANT (ADDRESS): Hosp. Info M.Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE ST MATTHEW CEM DATE Oct 24. 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS): E. J. SCHNUR 3125 LAFAYETTE AVE

20. FILED OCT 24 1938 J. F. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 10/19/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 8/8/38, 19 to 10/19/38, 19

I last saw her alive on 10/19/38, 19 Death is said to have occurred on the date stated above, at 8,45 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Thrombosis (Left Lenticulostriate)	
Hypertension	
Arteriosclerosis, general	

Other contributory causes of importance:

Name of operation Mann Date of .....

What test confirmed diagnosis? Phys Ex. 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? No

If so, specify .....

(Signed) [signature], M. D.

(Address) City 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, Jos B Vollmer, or by

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

Signed Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette av

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.