

OCT 20

938 REC'D NOV 4 1938

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

26898
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis
(b) Township Carondelet
(c) City
(d) Street No. Mehlville, Mo.
(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. 200

Registered No. 1704

2. PRINT FULL NAME Anna Margaret Dering

(a) Residence, No. Little Rock, Ark. 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 female
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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 27, 1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 7 21

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
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) Arkansas

FATHER
13. NAME Larance Dering

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia

MOTHER
15. MAIDEN NAME Rosie Farry

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Larance Dering Ark.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Hope DATE Oct. 20/38

19. FUNERAL DIRECTOR (ADDRESS) Fendler Und. Co. 7420 Michigan Ave

20. FILED OCT 20 1938 P. C. Meyer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 17 1938

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:

Acute Hemorrhagic cystitis of 2 weeks

Date of onset

10/17/38

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis? Autopsy 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? no
If so, specify.....

(Signed) John Starnes H. M. D.
(Address) Coroner of St. Louis County

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.

8.1.1.1
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STATEMENT BY LICENSED EMBALMER

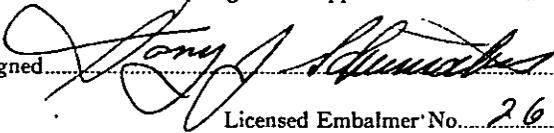
I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed 

Licensed Embalmer No. 2679 -

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36595
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. _____
 (b) Township _____ Primary Registration District No. _____ Registered No. _____
 (c) City _____ (d) Street No. _____ 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

(a) Residence, No. Anna M. D. Perry St.
Meleville (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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W
(Write the word)

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

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

7. AGE YEARS <u>3</u>	MONTHS <u>7</u>	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
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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 120 1934 T. R. Meyer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 17 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____, 19____

I last saw him _____ 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:

Acute hemorrhagic congestion of brain
MALARIA (tertian) 10/17/38

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? Microscopic study 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? Arkansas
 (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) John Q. Connell M. D.
 (Address) Carover

SUPPLEMENT

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. REGISTERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

