

1939 JAN 11

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

41443
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis
(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. 791
Primary Registration District No. 1003
Registered No. 11135
(d) Street No. City Hospital
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. 3776 West Pine St. 19
(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 3-1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
51 7 22

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. Self
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) Kentucky

FATHER 13. NAME Joe Baker

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Ronda Schafer
3776 W. Pine

18. BURIAL, CREMATION, OR REMOVAL PLACE Webb City MO DATE 12/26/1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) McLaughlin
2317 Lafayette

20. FILED 28 1939 J. J. [Signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-25-1938

22. I HEREBY CERTIFY, That I attended deceased from 12-8, 1938, to 12-25, 1938.
I last saw her alive on 12-25, 1938. Death is said to have occurred on the date stated above, at 12:15 a.m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of ovary

Other contributory causes of importance: MI

Name of operation..... Date of.....
What test confirmed diagnosis? yes 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) W. M. [Signature], M. D.
(Address) City, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

MISSISSIPPI
1934

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. Cooper

or by *me*

Registered Apprentice No., working under my personal supervision.

Signed *L.R. Cooper*

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.