

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH791
1003

264

Do not use this space.

264

Registered No. 264

1. PLACE OF DEATH

- (a) County Deaconess Hospital Registration District No. _____
- (b) Township 6150 Oakland Ave Primary Registration District No. _____
- (c) City St. Louis, Mo. (d) Street No. _____ St. _____
- (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. 3170 (Stillborn) bedbetter TWIN # 2 St. 6
- (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)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 4, 1939

7. AGE YEARS MONTHS DAYS 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) St. Louis Missouri

- FATHER 13. NAME Wes Jackson bedbetter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chewalla Tenn.

- MOTHER 15. MAIDEN NAME Esther Sarnata Cato

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brenbrier Missouri

17. INFORMANT (ADDRESS) Mother Esther Cato bedbetter

18. BURIAL, CREMATION, OR REMOVAL PLACE DEACONESS HOSPITAL Twn 4 1939

19. FUNERAL DIRECTOR (ADDRESS) DEACONESS HOSPITAL 6150 OAKLAND AVE

20. FILE JAN 9 1939 J. B. Brubaker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 1939

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 PROVA

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

Other contributory causes of importance _____

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) Heleen M. D.

(Address) 574 Union Post

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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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.....

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.)