

REC'D FEB 10 1939

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

514

Do not use this space.

514

Registered No. 514

791
1003

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City..... **St Louis** (d) Street No. **City Hospital** 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 **Norma Jean Brentlinger**

(a) Residence, No. **3210 N. Warf Str** St. **26** (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) **Infant**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Oct 10th 1938**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 -- 6 --

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**FATHER 13. NAME **Adam Brentlinger**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**MOTHER 15. MAIDEN NAME **Geneve Gieslow**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Indiana**17. INFORMANT **Adam Brentlinger**
(ADDRESS) **3210 N. Warf**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Calvary Cem.** DATE **Jan. 17th 1939**19. FUNERAL DIRECTOR (NAME) **Edward Koch**
(ADDRESS) **3516 1/2 14th**20. FILED **JAN 17 1939**
J. E. Bruck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 15 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 **4:30 p.m.**
The principal cause of death and related causes of importance were as follows:

Malnutrition
Yantis Esthetics
January
Date of onset

Other contributory causes of importance:

Malnutrition

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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? **Yes**If so, specify **Malnutrition**(Signed) **Walter Perry**(Address) **Deputy Coroner**

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.

THE NATIONAL BOARD OF EXAMINERS
FOR THE EMBALMING INDUSTRY

No embalming C.F.

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.....
..... Licensed Embalmer No.....

P. O. Address.....

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.