

REC'D FEB 10 1939

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

589

Do not use this space.

## 1. PLACE OF DEATH

(a) County ..... Registration District No. **1003**  
 (b) Township ..... Primary Registration District No. .... Registered No. **589**  
 (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

(a) Residence, No. **6145 Wm Stanley** **Warrens City, Jan 119 Raton St. Ave N. R.**  
 (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) **Divorced**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 7 1865**  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**74 8 12**  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**  
 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) **Barkersville, Mo**

FATHER 13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT (ADDRESS) **Wm Stanley Harlan Kansas City, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Own Residence** DATE **Jan 19 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Budwick Funeral Home 1936 St Louis Ave**

20. FILED **JAN 19 1939** **Joe Budwick** Local Registrar.

**No** MEDICAL CERTIFICATE OF DEATH  
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1/18/39** 19  
 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 **7:30 A.M.**  
 The principal cause of death and related causes of importance were as follows:

**Chronic Myocarditis**  
**Asthenia & Dehydration**  
 Other contributory causes of importance: **None**  
 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? **No**  
 If so, specify .....  
 (Signed) **Joseph M. Quinn**  
 (Address) **Deputy Coroner**

**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, .....

*W. O. Embalmer*

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.**