

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

REC'D FEB 10 1939

688
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No..... 791
 (b) Township..... / Primary Registration District No..... 1008
 (c) City ST LOUIS / (d) Street No. DESLOGE 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. 230 3525 N 229 St St. 20 (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) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN 21ST 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 MO

FATHER 13. NAME JOHN BOGOWITH

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis MO

MOTHER 15. MAIDEN NAME FRANCIS MERTENS MEYER

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis MO

17. INFORMANT (ADDRESS) JOHN BOGOWITH 3525 N 229 St

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE Jan 23d 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edward Koch 3514 N 14th St

20. FILED JAN 23 1939 J. F. Budner Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/21 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/21 1939 to 1/21 1939

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4:13 P.M.

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

STILL BIRTH

Date of onset

Other contributory causes of importance:

ATELECTASIS BOTH LUNGS

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? yes

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) E. A. Mitchell, M. D.

(Address) 1325 S. Grand

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.

STATEMENT BY LICENSED EMBALMER

W. O. 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.