

REC'D FEB 10 1939

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

789
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

Registration District No. 791
Primary Registration District No. 1003

Registered No. 789

(d) Street No. St. Ann's Hospital
(If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 4633 N. Market St St. //
(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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Stillborn

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as lawyer, 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 Joseph Pille

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

MOTHER 15. MAIDEN NAME Marg. Schimmelphenig

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

17. INFORMANT Jos. Pille
(ADDRESS) 4633 N. Market St.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Calvary DATE Jan. 25 1939

19. FUNERAL DIRECTOR (NAME) Promehing Ind. Co
(ADDRESS) 4746 N. Florissant Ave.

20. FILED JAN 25 1939

J. B. Bredel
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-24-1939

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 12:35 a.m.

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

Stillborn Macerated Date of onset

Test for syphilis negative

Other contributory causes of importance:

Fatty degeneration of placenta. Thromboses of umbilical cord.

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?.....

If so, specify

(Signed) Percy H. Swahler M. D.

(Address) St. Ann's Hospital, St. Louis

Not embalmed

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.