

RECD FEB 10 1939

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

852  
Do not use this space.

791  
1003

Registered No. 852

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City ..... (d) Street No. DE PAUL 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 ANNIE E. FLORENTIN

(a) Residence, No. 4067 WASHINGTON AVE St. 19  
 (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 FEMALE  
 4. COLOR OR RACE WHITE  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ROBERT FLORENTIN  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC. 11, 1868  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
 70 x 1 84

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. HOUSEWIFE  
 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) MISSOURI

FATHER  
 13. NAME JAMES CALBREATH

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

MOTHER  
 15. MAIDEN NAME HATTY COURTNEY

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

17. INFORMANT. ROBERT FLORENTIN  
 (ADDRESS) 4067 WASHINGTON BLVD

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE GALVARY CENTER DATE JAN 20 1939

19. FUNERAL DIRECTOR (NAME) Goodhart & Goodhart  
 (ADDRESS) 2228 N. Main Ave

20. FILED JAN 27 1939 J. F. Brudick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 25 1939  
 22. I HEREBY CERTIFY, that I attended deceased from Jan 19 1939, to Jan 25 1939  
 I last saw him alive on Jan 19 1939. Death is said to have occurred on the date stated above, at 10:55 a.m.  
 The principal cause of death and related causes of importance were as follows:

Myocardial Heart Disease  
 Coronary Arteriosclerosis  
 atherosclerosis  
 Date of onset 1/10/39

Other contributory causes of importance:  
 Pneumonia Lobar 1/10/39

Name of operation Lobotomy Date of operation 1/20/39  
 What test confirmed diagnosis? Lobotomy 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) E. P. G. \_\_\_\_\_, M. D.  
 (Address) \_\_\_\_\_

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**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Charles Goodhart*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Charles Goodhart*

Licensed Embalmer No. *2777*

P. O. Address *Lowell, Ma*

**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.**