

REC'D FEB 10 1939

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

950

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
 (b) Township..... Primary Registration District No. 1003
 (c) City..... St. Louis (d) Street No. Homer Phillips Hospital St.
 Life (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.

Registered No. **950****2. PRINT FULL NAME** 650 Vivian Herron

(a) Residence, No. 3013 Easton St. 21 (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 F	4. COLOR OR RACE C	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) Oct. 31, 1937				
7. AGE	YEARS 1	MONTHS 2	DAYS 24	If LESS than 1 day, hrs. or min.
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) Saint Louis (STATE OR COUNTRY) Missouri				
FATHER	13. NAME Sam Slaten unknown			
	14. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME Willa M Herron			
	16. BIRTHPLACE (CITY OR TOWN) Mississippi (STATE OR COUNTRY)			

MEDICAL CERTIFICATE OF DEATH21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 25**, 19**39**22. I HEREBY CERTIFY, That I attended deceased from **Jan. 23**, 19**39**, to **Jan. 25**, 19**39**I last saw her alive on **Jan. 25**, 19**39**. Death is said to have occurred on the date stated above, at **9:25p** m.

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

Bronchopneumonia PrimaryDate of onset
1/23/39Other contributory causes of importance: **107a**Name of operation..... Date of.....
What test confirmed diagnosis? **clinical** Was there an autopsy? **YES**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) **Wm B Smith**, M. D.
(Address) **2601 N Whittier**17. INFORMANT **Evelyn Hilliard**
(ADDRESS) **2601 N Whittier**18. BURIAL, CREMATION, OR REMOVAL **burial**
PLACE ~~St. Louis~~ DATE **1-31-39**19. FUNERAL DIRECTOR (NAME) **Emmett Foxey Co**
(ADDRESS) **3421 Delmas**20. FILED **JAN 30 1939**
J. P. Beeler Local Registrar

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....
working under my personal supervision.

John Embalmer
Signed *Pauper*

.....
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.