

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH791  
1003977  
Do not use this space.

## 1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. .... Registered No. **977**  
 (c) City St. Louis, Mo. (d) Street No. St. Louis Children's 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 Knierim, Clarice Ann

(a) Residence, No. Waterloo, Illinois R.R. 3 NR (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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-30-34

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
4 7 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child  
 9. Industry or business in which work was done, as saw mill, bank, etc. Child  
 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 Milton

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

MOTHER 15. MAIDEN NAME Viola Vogt

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

17. INFORMANT (ADDRESS) S Vedder  
500 S. Kings highway

18. BURIAL, CREMATION, OR REMOVAL PLACE H. Matthews DATE Feb 3, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wacker Kellie  
2331 L. Broadway

20. FILED JAN 31 1939 J. F. Budick Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-31-1939

22. I HEREBY CERTIFY, That I attended deceased from 1-30-1939 to 1-31-1939, 1939

I last saw her alive on 1-31-39, 1939 Death is said to have occurred on the date stated above, at 4<sup>10</sup> a.m.

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

Strabismic Acute  
Pharyngitis Acute Non Diphtheritic  
? Septic  
115a

Date of onset  
1-28-39

Other contributory causes of importance:  
Congenital cerebral defect Burt

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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 R. D. Bluffe M. D.

(Signed) R. D. Bluffe M. D.

(Address) 500 S. Kings Highway

**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, .....

*Francis J. Gylford Sr.*

or by .....

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

Signed .....

*Francis J. Gylford Sr.*

Licensed Embalmer No. ....

*2645*

P. O. Address .....

*St Louis Mo*

**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.**