

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.

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

REC'D FEB 27 1939

3742
Do not use this space.

1. PLACE OF DEATH

(a) County St. Genevieve Registration District No. 781
(b) Township _____ Primary Registration District No. 4467 Registered No. 1
(c) City St. Marys (d) Street No. _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 21st 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 0 0 0 0 0 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
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. Marys, Mo.

FATHER 13. NAME Gus Arbuckle

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

MOTHER 15. MAIDEN NAME Francis Grifford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) James Mount, Mo.

17. INFORMANT (ADDRESS) Gus Arbuckle
St. Marys, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Genevieve DATE 1/24 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leo C. Roeder
St. Genevieve, Mo.

20. FILED 1/21 1939 G. G. Thomas
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21st 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 21 1939, to Jan 21 1939
I last saw her alive on Jan 21 1939 Death is said to have occurred on the date stated above, at _____ m.

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

Respiratory paralysis Date of onset 1/21/39
160 lbs

Other contributory causes of importance: Injured at birth
Breech extraction

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 _____
(Signed) J. O. Wilkins, M. D.
St. Marys, Mo. (Address)

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.