

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.

JAN 24 1939
FEB 7 1939

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

3802
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township _____ Primary Registration District No. 200 Registered No. 142
(c) City Jennings (d) Street No. 8817 Scott Av. 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

Barbara Ruth Chesnick
(a) Residence, No. 8817 Scott Av St. (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 married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 21 - 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 5 2

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. House Work
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) Belleville Ill.

FATHER 13. NAME John Beckett

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) John Chesnick
8817 Scott Av.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE Jan 27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Permschwig Und. Co.
4746 W. Florissant St. S.E.

20. JAN 24 1939 Local Registrar J. C. Meyer

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-23, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-28, 1938, to 1-23, 1939

I last saw her alive on 1-22, 1939. Death is said to have occurred on the date stated above, at 12:30 p. m.

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

Chr. interstitial nephritis Date of onset 12/4/38
Cerebral of liver

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? Exam 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) W. C. Meyer M. D.
(Address) 5024 N. Union

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 *Guy W. Wilkins*

Licensed Embalmer No. *3575*

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.