

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

4337
Do not use this space.

REC'D MAR 13 1939

791
1003

Registered No. **1030**

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 or
 (c) City..... **St. Louis** (d) Street No. **Homer Phillips 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 **40** yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *65⁹* **Lena Prince**

(a) Residence, No. **2728 Pine** 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

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Separated

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 25** 19**39**

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

22. I HEREBY CERTIFY, That I attended deceased from
June 7, 19**37**, to **Jan. 25**, 19**39**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 25, 1897**

I last saw her alive on **Jan. 25**, 19**39** Death is said to have occurred on the date stated above, at **5:45 A.M.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
42 -- --

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

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

Pulmonary edema Date of onset **6/7/37**

12. BIRTHPLACE (CITY OR TOWN) **Illinois**
 (STATE OR COUNTRY)

Other contributory causes of importance:
Neuro Lues

FATHER 13. NAME **Will Covington**

14. BIRTHPLACE (CITY OR TOWN) **Missouri**
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Mary ?**

16. BIRTHPLACE (CITY OR TOWN) **Illinois**
 (STATE OR COUNTRY)

17. INFORMANT **Evelyn Hilliard**
 (ADDRESS) **2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Home* DATE **1-27-39**

19. FUNERAL DIRECTOR (NAME) **W. R. Rucker 3501 Park**
 (ADDRESS)

20. FILED **FEB 1 1939**
J. D. Bredenk
 Local Registrar.

Name of operation Date of
 What test confirmed diagnosis? **clinical** 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
 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) **Herbert Emerson** M. D.
 (Address) **2601 N Whittier**

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.

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.