

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

4561

Do not use this space.

791

1008

Registered No. 1254

City Hospital No. 1

MAR 13 1939

1. PLACE OF DEATH

- (a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) St. Louis ..... City Hospital No. 1 ..... St.  
 (d) Street No. .... (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 U. D. O. Sarah Miles

- (a) Residence, No. 1508 South 13th St. [23] (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (widowed)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/6/39 19

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed wife of Simon

22. I HEREBY CERTIFY, That I attended deceased from 2/1/39, 19, to 2/6/39, 19.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 25, 1876

I last saw her alive on 2/6/39, 19. Death is said to have occurred on the date stated above, at 8.20 a.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
63 -- 11

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. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. nil  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

Acute Lungs & organ failure  
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

Other contributory causes of importance: JK

FATHER 13. NAME Anthony Jackson

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park in DATE 2/8/39, 19.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. W. McLaughlin  
2301 Lafayette Avenue

20. FILE FEB 8 1939 J. D. Braddock Local Registrar.

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? 1  
 If so, specify Yes. J. D. Braddock, M. D.  
 (Signed) J. D. Braddock (Address) City Hospital No. 1

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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lapa

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**