

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.

RECD MAR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

791
1008

4746

Do not use this space.

1439

1. PLACE OF DEATH

(a) County.....

Registration District No.....

(b) Township.....

Primary Registration District No.....

(c) City St. Louis

(d) Street No. City Hospital No. 1 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

Jennie Carlson

(a) Residence, No. 1443 Madison St.

(Usual place of abode, if no street address, write county or city)

(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 (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF Widowed Wife of Charles

(OR) WIFE OF

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

Dec 21, 1873

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1

65

1

20

day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

hwk

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. Louis, Missouri

FATHER

13. NAME

Charles West

14. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Sweden

MOTHER

15. MAIDEN NAME

Marie Jackson

16. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Sweden

17. INFORMANT (ADDRESS)

Hosp. Info M. Kent

18. BURIAL, CREMATION OR REMOVAL

PLACE St. Peter's

DATE 2/14/39

19. FUNERAL DIRECTOR (NAME)

(ADDRESS)

A. W. McLaughlin
2301 Lafayette Avenue

20. FILED

FEB 14 1939

J. D. Brubaker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

2/11/39

19

22. I HEREBY CERTIFY That I attended deceased from

2/3/39

2/11/39

19

I last saw her alive on 2/11/39, 19..... Death is said

to have occurred on the date stated above, at 6.07 a.

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

Hypertensive heart
Chronic heart
Failure
Hypertensive heart
Failure

Date of onset

Other contributory causes of importance:

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)

Dr. J. D. Brubaker
City Hospital No. 1

M. D.

(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,

Paul A. Keith

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Paul A. Keith

Licensed Embalmer No. *3612*

P. O. Address *2317 Lafayette*

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.