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.

REC'D MAR 13 1939

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

4935
Do not use this space.

791

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township or City ..... Primary Registration District No. ..... Registered No. 1628
(c) ST. LOUIS MO. (d) Street No. MISSOURI BAPTIST 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 3 LENORA KIDWELL.
(a) Residence, No. 3658 A LAFAYETTE AV. St. 17
(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): MARRIED
5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF: O. W. KIDWELL.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): NOV. 17-1887
7. AGE: YEARS 51 MONTHS 3 DAYS 1 If LESS than 1 day, ... hrs. or ..... min.

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. HOUSEKEEPER.
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): MISSOURI 6

FATHER
13. NAME: HENRY AHERNS. 5
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): IRELAND. 5

MOTHER
15. MAIDEN NAME: FRANCES UNK.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): IRELAND.

17. INFORMANT (ADDRESS): O. W. KIDWELL 3658 LAFAYETTE AV.
18. BURIAL, CREMATION, OR REMOVAL PLACE: NEW PICKERS CEM. DATE: FEB 21 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): E. J. Schnur. 3125 Lafayette Av.
20. FILED FEB 20 1939 J. D. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): FEB 18, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1939, to Feb 18, 1939
I last saw her alive on Feb 18, 1939. Death is said to have occurred on the date stated above, at 10 35 A.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cystic Thyroid, non malignant Chronic Bronchitis	1937
Other contributory causes of importance: Acute Myocarditis	Feb 6 39

66

Name of operation: Thyroidectomy Date of: Feb 14-39
What test confirmed diagnosis? Biopsy 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. Sansbury, M. D.
(Address) 3258 - Lafayette

(Licensed Embalmer's Statement on Reverse Side)

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. 4014

P. O. Address 5125 Lafayette

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

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