

REC'D APR 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH791
10038228
Do not use this space.

1. PLACE OF DEATH

(a) County.....

(b) Township.....

(c) City.....

(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No.

Primary Registration District No.

(d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) St.

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widower

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

1/20, 1939

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

Unknown

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at 10:35 a.m.

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

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

abt: 58

OCCUPATION

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

9. Industry or business in which work was done, as law mill, bank, etc.

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

Unemployed

Acute dilation of Right Auricle and Ventricles with Corneal Hypertrophy

Date of onset

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED MAR 2 1939

Other contributory causes of importance:

Chronic Hypertrophic Cardiomyopathy, Chronic Diffuse Nephritis

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?..... No

If so, specify.....

(Signed)..... 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,

....., 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.