

206  
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 APR 12 1939

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

791  
1003

9259

Do not use this space.

3024

## 1. PLACE OF DEATH

(a) County St. Louis Registration District 1003  
 (b) Township 1 Primary Registration District 3024  
 (c) City St. Louis (d) Street No. En Route City Hospital St.  
 (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

(a) Residence, No. No. Name St. St. Louis (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Unknown

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

7. AGE YEARS 57 MONTHS — DAYS — If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
 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) Mo.

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

MOTHER 15. MAIDEN NAME 9

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 11

17. INFORMANT (NAME) Lynna Armstrong-P.D.

18. BURIAL, CREMATION, OR REMOVAL PLACE New Pickney Cem. DATE 4-4-39

19. FUNERAL DIRECTOR (NAME) W. H. Brown

(ADDRESS) 2929 Jefferson

20. FILED MAR 31 1939

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/22/39

22. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19.

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

to have occurred on the date stated above, at 7:20 m.

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

Lobar Pneumonia

Other contributory causes of importance:

Name of operation ✓ Date of 24

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) Joseph M. Zuercher

(Address) Deputy Coroner

**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.**