

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

9775
Do not use this space.

REC'D APR 17 1939

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township W. C. Mo Primary Registration District No. 1002
 (c) City W. C. Mo (d) Street No. 170 San Diego Registered No. 1381
 (e) Length of residence in city or town where death occurred 3 1/2 yrs. (If death occurred in Hospital or Institution, write its name instead of street and number) St. Joseph's Hosp.
 (f) How long in U. S., if of foreign birth? 3 1/2 yrs. 11 mos. 1 ds.

2. PRINT FULL NAME
 (a) Residence, No. 1870 W. 11th 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-28-39

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

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

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) W. C. Mo

FATHER
 13. NAME Agamenon Hebler
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. C. Mo

MOTHER
 15. MAIDEN NAME Mina Crabtree
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. C. Mo

17. INFORMANT (ADDRESS) Records Dept. St. Joseph's Hosp.

18. BURIAL, CREMATION, OR REMOVAL W. C. Mo DATE 3-31-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John J. Campbell

20. FILED Mar 31, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-28-39

22. I HEREBY CERTIFY, That I attended deceased from 3-27-39 19, to 3-28-39 19.
 I last saw him alive on 3-28-39 19. Death is said to have occurred on the date stated above, at 6:40 a.m.
 The principal cause of death and related causes of importance were as follows:
Prematurity
159

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

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) P. F. De Maria M. D.
 (Address) P. F. De Maria - Mo

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.