

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**

13308
Do not use this space.

REC'D MAY 10 1939

**791
1003**

Registered No. 3650

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No.....

(c) City..... St. Louis..... (d) Street No. Homer Phillips Hospital..... St.
Life (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 Lizzie Thomas

(a) Residence, No. 2010 Carr St. 21 (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 F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 28, 1874

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>65</u>	<u>1</u>	<u>13</u>	

OCCUPATION

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

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) Missouri

FATHER

13. NAME George Kain

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

MOTHER

15. MAIDEN NAME Jenny Wright

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

17. INFORMANT (ADDRESS) Evelyn Hilliard
2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE St Peters Cms. DATE 4 20 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wright Funeral Home
3100 Easton Ave.

20. FILED APR 19 1939 J. D. Budek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 13, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 3, 1939, to April 13, 1939

I last saw h. EC alive on April 13, 1939. Death is said to have occurred on the date stated above, at 4:40 p. m.

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

Pulmonary tuberculosis

Date of onset 4/3/39

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis? clinical 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) Joseph Hilliard, M. D.
(Address) 2601 N Whittier

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 me

Chas. Gaines

Registered Apprentice No. 2349

working under my personal supervision.

Signed

Chas. Gaines

Licensed Embalmer No. 2349

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.