

REC'D MAY 10 1939

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

791  
1003

13446  
Do not use this space.

3788

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No..... Registered No.....  
(c) City St. Louis (d) Street No..... City Hospital No. 1 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

(a) Residence, No. 4948 / Farlin St. 7  
(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 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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 11, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 11 11

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) Tennessee

FATHER 13. NAME Cooper Curlin

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

MOTHER 15. MAIDEN NAME Belle Verhayna

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Union City, Tenn DATE 4-23 1919

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wyllie & Co.  
Burchard & Son

20. FILED APR 24 1939 J. F. Burchard Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/22/39 19

22. I HEREBY CERTIFY, That I attended deceased from 4/11/39 19 to 4/22/39 19.

I last saw him live on 4/22/39 19. Death is said to have occurred on the date stated above, 6 a. m.  
The principal cause of death and related causes of importance were as follows:

cholecystectomy  
Pertussis - Generalized acute

Date of onset 4-18-39

Other contributory causes of importance:  
Gall stones | 26

Name of operation cholecystectomy Date of 7-18-39

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) David Weiser M. D.  
(Address) City Hospital

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.

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**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.....

*Max Mayfield*

Licensed Embalmer No. *3077*

P. O. Address.....

*St Louis Mo*

**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.**