

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

JUN 12 1939

791
1003

16486
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No..... 4020
(c) City or ST. LOUIS MO. (d) Street No. 3540 AVISTA AV. 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. 3540 AVISTA AV. St. 17 (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 FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG. 17-1866
7. AGE YEARS 72 MONTHS 8 DAYS 13 If LESS than 1 day, ... hrs. or min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. HOUSEWORK.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) ST. LOUIS, MISSOURI (STATE OR COUNTRY)

FATHER 13. NAME FRANK SIMS

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

MOTHER 15. MAIDEN NAME ETTA LUBBY

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

17. INFORMANT NELLIE SIMS (ADDRESS) 3540 AVISTA AV.

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEM. DATE MAY 2 1939

19. FUNERAL DIRECTOR (NAME) E. J. Schur (ADDRESS) 3125 Lafayette Av.

20. FILED MAY 1 1939 J. D. Buehler Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) APRIL 30 19 39

22. I HEREBY CERTIFY, That I attended deceased from April 28, 1939, to April 30, 1939

I last saw her alive on April 30, 1939 Death is said to have occurred on the date stated above, at 2:30 A.M.

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

permyocarditis, caused by (Date of onset) 4/27/39
bronchial pneumonia

Other contributory causes of importance: 107a
bronchial pneumonia 4/28/39

Name of operation Ed. Phys. & Clinical Inst. Date of operation 4/28/39

What test confirmed diagnosis Ed. Phys. & Clinical Inst.

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. Dr. J. Schur M. D.

(Signed) Dr. J. Schur (Address) 3608 S. St. Louis 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.....

Joe B. Vollmer

Licensed Embalmer No. *41014*

P. O. Address *3125 Lafayette Ave.*

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.