

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

16530  
Do not use this space.

791  
1008

4064

1. PLACE OF DEATH

(a) County .....  
(b) Township .....  
(c) City St. Louis (d) Street No. City Hospital Hospital #1. St. City Hospital Hospital #1.  
(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

650 John H. Mreen  
(a) Residence, No. 3650 Lindell Blvd. St. 19  
(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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 4, 1884.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
54 II 27

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor  
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 William Mreen

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

MOTHER 15. MAIDEN NAME Mary Ann Meyer

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

17. INFORMANT Herman Weidinger  
(ADDRESS) Florissant, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Florissant, Mo. DATE May 4/39.

19. FUNERAL DIRECTOR Jos. W. Clark,  
(ADDRESS) 1125 Hodiament Ave.,

20. FILED 5/24/39 J.B. Brubaker  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 1/39. 1939

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 1.35 P.M.

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

Cerebral Apoplexy  
Chronic Interstitial Nephritis

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) Jos. W. Clark  
(Address) 1125 Hodiament Ave.

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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.

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**STATEMENT BY LICENSED EMBALMER**

I, Jos. W. Clark, Licensed Embalmer No. I66I

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Jos. W. Clark*

Licensed Embalmer No. I66I

**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.)**