

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

17117  
Do not use this space.

REC'D JUN 12 1939

791  
1008

1. PLACE OF DEATH

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

(b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. **4651**

(c) City \_\_\_\_\_ (d) Street No. **Desloge Hospital** 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 **Mrs. McCoy**

(a) Residence, No. **3321 Eads Ave.** 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) **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **August 25, 1902**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<b>36</b>	<b>8</b>	<b>26</b>	

OCCUPATION

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

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 **John Walsh**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

MOTHER

15. MAIDEN NAME **Lulu Metz**

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

17. INFORMANT **Daniel McCoy**  
(ADDRESS) **3321 Eads Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem.** DATE **5-24-39**

19. FUNERAL DIRECTOR (NAME) **Peetz Bros.,**  
(ADDRESS) **3029 Lafayette Ave**

20. FILED **MAY 22 1939** **J. B. Budeck** Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 20, 1939**

I HEREBY CERTIFY, That I attended deceased from **May 11, 1939, to May 20, 1939**

I last saw her alive on **May 20, 1939**. Death is said to have occurred on the date stated above, at **2:15 p. m.**

The principal cause of death and related causes of importance were as follows:  
**Subacute Bacterial Endocarditis (Streptococcus Viridans)**

Date of onset **Unknown**

Other contributory causes of importance: **A**

Name of operation **None** Date of \_\_\_\_\_  
What test confirmed diagnosis **Autopsy**. Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following: **No**

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 \_\_\_\_\_

(Signed) **G. O. Brown**, M. D.  
(Address) **1325 S. Grand**

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.

**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 *Frank J. Gwers*

Licensed Embalmer No. *2245*

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.**