

REC'D JUN 1 1939

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

17134
Do not use this space.

791
1003

Registered No. 4668

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.
 (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 4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 330 Della Hatwood

(a) Residence, No. 3829a Windsor St. 11
 (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 F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Separated
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 5, 1896
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 2 14
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 19, 1939 19 ..
 22. I HEREBY CERTIFY, That I attended deceased from April 24, 1939, 19 .., to May 19, 1939, 19 ..
 I last saw her alive on May 19, 1939, 19 .. Death is said to have occurred on the date stated above, at 4:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Hypertensive heart disease

Date of onset 4/24/39

Other contributory causes of importance:
Chronic nephritis

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 Yes
 (Signed) H. G. Lyman M. D.
 (Address) St. Louis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

FATHER 13. NAME Charles Munn

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

MOTHER 15. MAIDEN NAME Priscilla Robinson

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

17. INFORMANT (ADDRESS) Evelyn Hilliard
2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE May 25, 19 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mary Wade
4202 Finney

20. FILED MAY 28 1939 J. B. Bredet
 Local Registrar.

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.....

Licensed Embalmer No. *2698*

P. O. Address *2769 Route*

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.