

REC'D JUN 12 1939

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

17215

Do not use this space.

4749

1. PLACE OF DEATH

(a) County St. Louis Mo Registration District No. 791
 (b) Township St. Louis Mo Primary Registration District No. 1008
 (c) City St. Louis Mo (d) Street No. St. Ann Hospital St. St. Ann Hospital
 (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. 447 St. Ann Hospital St. St. Ann Hospital
 (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 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) May 25th - 1939
 7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY,hrs. ormin.
Still Born

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.
 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) St. Louis Mo13. NAME Elmer Delaloye14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo15. MAIDEN NAME Carpenter16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo17. INFORMANT Elmer Delaloye (ADDRESS) St. Ann Hospital18. BURIAL, CREMATION, OR REMOVAL PLACE St. Charles DATE May 25 - 3919. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank D. G. 7420 Michigan Ave20. FILED St. Louis Mo

MAY 25 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from St. Ann Hospital, 19....., to Still Born, 19....., 19.....
 I last saw him live on Still Born, 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:

Distended uterine artery section
 Other contributory causes of importance:
Toxaemia of Pregnancy
Pre-maturity

Name of operation none Date of.....
 What test confirmed diagnosis? Autopsy 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.....
 (Signed) John B. O'Neill, M. D.
 (Address) 1332 Missouri Street

Not embalmed

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.....

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.