

REC'D JUN 12 1939

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

17283

Do not use this space.

## 1. PLACE OF DEATH

- (a) County 3 Registration District No. ....  
 (b) Township 1 Primary Registration District No. .... Registered No. 4817  
 (c) or City en route City Hosp. No. 2 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (d) Street No. .... (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

- (a) Residence, No. 535 Mallic Windom St. 23 (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. m. 4. COLOR OR RACE C. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 29 - 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
44 18 5 23

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. Domestic  
 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) more vidu miss

13. NAME Doc. Brown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) north caliner

15. MAIDEN NAME Mallic Brown

15. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) more vidu miss

17. INFORMANT (ADDRESS) Henry Stupandu  
1432 2<sup>d</sup> St.

18. BURIAL, CREMATION, OR REMOVAL PLACE father dickens DATE 5-27- 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. J. B. ...  
14-19 2<sup>d</sup> St.

20. FILED MAY 27 1939 19 J. B. Budick (Local Registrar)

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 5:00 A.M.

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

Cerebral Hemorrhage (Apoplexy);  
Chronic Parenchymatous Nephritis

Date of onset

Other contributory causes of importance? 181

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 see above

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) W. H. ..., M. D.

(Address) ...

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X 16605  
BUREAU OF VITAL STATISTICS

**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.....

*myself*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Raymond G. Gehlke*

*City license #99*

Licensed Embalmer No. ....

*3985*

P. O. Address.....

*St Louis, Mo*

**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.**