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.

50 JUN 12 1939

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

791

17377
Do not use this space.

1. PLACE OF DEATH
(a) County
(b) Township
or
(c) City St. Louis
Registration District No. 1008
Primary Registration District No.
Registered No. 4911
(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 12 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 5 Laedene Thomas
(a) Residence, No. 1606 R Carr St. 25
(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): November 25, 1901
7. AGE: Years 37 | Months 5 | Days 19 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housework
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: unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

MOTHER
15. MAIDEN NAME: Mary Torrence
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

17. INFORMANT (ADDRESS): Evelyn Hilliard, 2601 N Whittier
18. BURIAL, CREMATION, OR REMOVAL: PLACE St Louis DATE 5/19/39
19. FUNERAL DIRECTOR (NAME) (ADDRESS): W. Richter 3500 Kings
20. FILED MAY 31 1939 J F Bredick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 14, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from April 19, 1939, to May 14, 1939
I last saw her alive on May 14, 1939. Death is said to have occurred on the date stated above, at 4:45a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Uterine Fibroid; prob. sarcoma of uterus; chr. bilateral salpingitis; acute suppurative nephritis	4/19/39

Other contributory causes of importance:
Pulmonary edema

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
(Signed) J. B. Martin, M. D.
(Address) 2601 N Whittier

(Licensed Embalmer's Statement on Reverse Side)

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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.