

REC'D JUN 8 1938

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

17682

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Haw Primary Registration District No. 1002
(c) City St. Louis (d) Street No. 17 E Sun Street Registered No. 2084
(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. 2804 Cherry St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, give a county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 2 1886
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 7 20
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc. None
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) MO 0

13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Recd Clerk (ADDRESS) 17 E Sun Street18. BURIAL, CREMATION, OR REMOVAL Funerary DATE 5-20-3919. FUNERAL DIRECTOR (ADDRESS) Dr. B. P. ... 536 Campbell St20. FILED May 19, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-17-39

22. I HEREBY CERTIFY, That I attended deceased from 5-8-39, 19____, to 5-17-39, 19____. I last saw him live on 5-17-39, 19____. Death is said to have occurred on the date stated above, at 4:30 pm.
The principal cause of death and related causes of importance were as follows:

Bladder Calculus Date of onset _____
Post operative Cystotomy
Bilateral Hydrophrosis
Other contributory causes of importance: 93C
Chronic Myocarditis

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 _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Dr. B. P. ...
(Address) 17 E Sun Street

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.