

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

DOM-1-1-33 I X14023

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.

MAY 6 1939 DEC'D JUN 8 1939

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

19773
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis
(b) Township
(c) City Pine Lawn
(e) Length of residence in city or town where death occurred

3
1

Registration District No.
Primary Registration District No.

(d) Street No. Mother of Good Counsel Home St.
(If not located in Hospital or institution, give name instead of street and number)
(f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 958

2. PRINT FULL NAME

230 Mrs. Elizabeth Jost
(a) Residence, No. 4613 Louisiana St.

(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) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10/2/1862

7. AGE YEARS 76 MONTHS 7 DAYS 24 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
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) Columbia, Ill.

FATHER 13. NAME Unknown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Jos Jost 4613 Louisiana Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE S. S. Peter & Paul DATE May 29 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. H. Gebken, Lx 2 Co 78 4 1/2 Menomonee St.

20. FILE MAY 26 1939 R. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/26/39 19

22. I HEREBY CERTIFY, That I attended deceased from 5/10/39, 19, to 5/26/39, 19.

I last saw her alive on 5/25/39, 19. Death is said to have occurred on the date stated above, at 6:10 A

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

Cerebral apoplexy left side before entering Home of Incurables with complete Hemiplegia involving all of right side. Generalized arteriosclerosis. Chr. Hypertension. Senile dementia.

Other contributory causes of importance: Myo Carditis? Myo cardial failure. 5/10/39

Uremia-Uremic coma. 5/10/39

Died in the Home of Incurables-6825 Natural Bridge Rd.

Name of operation _____ Date of _____

What test confirmed diagnosis? History 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? NO.

If so, specify _____ (Signed) R. Meyer, M. D.

707 (Address) 5718 Jennings Road.

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.