

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

I X16605

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.

REC'D JUL 12 1939

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

20207  
Do not use this space.

1. PLACE OF DEATH

(a) County..... 3 Registration District No. 791  
(b) Township..... 1 Primary Registration District No. 1003  
(c) City or St Louis (d) Street No. Mississippi River Registered No. 5051  
(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 Clara Ubben

(a) Residence, No. 949 Harlem Ave St. 8  
(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) Dec., 17 Th 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
35 ----- 5 17

OCCUPATION 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. Housework  
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 Mo

FATHER 13. NAME Herman Ubben

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Therisa Abeln

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

17. INFORMANT (ADDRESS) Therisa Ubben  
949 Harlem Ave

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Calvary Cem. DATE June 5 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edmund Wash  
3516 4 14 St

20. FILED JUN 15 1939  
J. B. Brudick  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-4-39

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

I last saw h..... alive on..... 30, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 2:30 m.

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

Asphyxiation due to  
drowning in Mississippi  
River when descending  
jumping span of  
Municipal Bridge into  
river on Feb. 27-1939 about  
6:00 Pm  
Date of onset

Name of operation Juvenile Date of..... 70  
What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Suicide Date of injury 2/27/39

Where did injury occur?..... (Specify city or town, county, and State)  
Public Place  
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? No  
If so, specify.....

(Signed) Joseph M. Quinn  
(Address) Deputy Coroner

*No embalming*

**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.**