

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.

JUL 12 1939

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

20214

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1008**
(c) City **St. Louis** (d) Street No. **City Hospital** St. **5058**
(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

Emma McKinney
(a) Residence, No. **4403 N. 2nd. St.** St. **20** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Wife of Joe. McKinney**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 25, 1906**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 4 7

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
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) **Hot. Woodruff County Arkansas**

FATHER 13. NAME **Monroe Sanders**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unk. W**

MOTHER 15. MAIDEN NAME **Unk.**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unk. W**

17. INFORMANT (ADDRESS) **Joseph McKinney 4403 N. 2nd. St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Friedens Cem.** DATE **6/5, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Suedmeyer & Sons 3934 N. 20th St.**

20. FILED **JUN 5 1939** **J. B. Bruckner** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6/2, 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 _____ m.
The principal cause of death and related causes of importance were as follows:

Post Partum Hemorrhage
Retained Placenta
Date of onset **14th**

Other contributory causes of importance:

Retained Placenta

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) **Joseph McKinney**
(Address) **Deputy Coroner**

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.....

Geo. P. Schubert, Registered Apprentice No.
working under my personal supervision.

Signed Geo. P. Schubert

Licensed Embalmer No. 2212

P. O. Address 5118 N. Kingshighway

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.