

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

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.

RECD JUL 12 1939

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

20401
Do not use this space.

791
1003

Registered No. 5245

1. PLACE OF DEATH

(a) County..... / Registration District No.....
 (b) Township..... / Primary Registration District No.....
 (c) City St. Louis Mo. (d) Street No..... BARNES 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JRECIA, MAE HANE

(a) Residence, No. 708 N. WESTERN St. MP MEXICO, MO.
 (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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Worthington Hane
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 45

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. H'wife
 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) Illinois

FATHER 13. NAME Irwin

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

MOTHER 15. MAIDEN NAME Allen

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

17. INFORMANT Worthington Hane
 (ADDRESS) Mexico Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mexico Mo. DATE 6/13/39

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc.
 (ADDRESS) 4700 Washington Ave.

20. FILED JUN 12 1939
J. F. Bredich
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 10th, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-10-1939 to 6-10-1939

I last saw her alive on 6-10-1939. Death is said to have occurred on the date stated above, at 5:28 a.m.

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

Influenza septicaemia
11/10

Date of onset 6 wks ago

Other contributory causes of importance:

Name of operation..... no Date of.....
 What test confirmed diagnosis? blood culture 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) Cyril M. McBoys, M. D.
 (Address) BARNES HOSPITAL

NOV 19 1957

5245

5245

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 *J. G. Sullivan*

Licensed Embalmer No. *1122*

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.