

WHITE 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.

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

21165
Do not use this space.

REC'D JUL 10 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Law Primary Registration District No. 1000 Registered No. 2033
(c) City St. Louis (d) Street No. 14 E. Sun West 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

James H. Talbott
(a) Residence, No. 1719 Broadway, K. C. Mo. 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 Male 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 Mary J. Talbott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 1st, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 7 11

OCCUPATION 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.
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) Missouri

FATHER 13. NAME John Talbott

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

MOTHER 15. MAIDEN NAME Susan Gloschen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT (ADDRESS) Mary J. Talbott
1719 Broadway, K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE June 15th, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Forster
918 Brooklyn Avenue, K.C. Mo.

20. FILED June 14 1939 M. M. Crowe, Ass't
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-12, 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-28, 1937, to 6-12, 1939
I last saw him alive on 6-12, 1939 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:

Carcinoma of Prostate with metastases Date of onset

Other contributory causes of importance:
Name of operation Proc 12-8-37 Date of 5-9-39
What test confirmed diagnosis? W Was there an autopsy? W

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) Paul Harris, M. D.
(Address) Supr. Gen. Hosp. St. Louis

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.