

RECD JUL 11 1939

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

21691
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
(b) Township Phillip Primary Registration District No. 3008 Registered No. 160
(c) City Phillip Mo (d) Street No. State Hospital no 1 St.
(U 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. State Hospital no 1 St. (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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) separated

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 23 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 - 10 9 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
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) St. Louis Mo.

13. NAME DK

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

15. MAIDEN NAME D.K.

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

17. INFORMANT (ADDRESS) Sophie Mayhies St Louis Mo 4416 Natural Bridge

18. BURIAL, CREMATION, OR REMOVAL PLACE St Louis Mo DATE June 20 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) General McFaray 1233 University

20. FILED 6/18 1939 R. N. Cruise Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 17 1939

22. I HEREBY CERTIFY That I attended deceased from April 1 1939 to June 17 1939

I last saw him alive on June 9 1939. Death is said to have occurred on the date stated above, at 1:45 m. The principal cause of death and related causes of importance were as follows:

General paralysis
DK
Other contributory causes of importance: Parasit. Aphthous mening. encephalitis

Name of operation none Date of DK
What test confirmed diagnosis? Lab 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?
If so, specify Fernit Thomas, M. D.
(Signed) State Health # 1
(Address) 106

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.

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.