

JUN 25 1939

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

23260
Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis Registration District No. 784
(b) Township _____ Primary Registration District No. 11 Registered No. 1127
(c) City Ruh Hgts (d) Street No. St. Mary's 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME June McLyene Maaks
(a) Residence, No. 721 M. McLEAN St. NR Lincoln, Illinois.
(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) February 24, 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
15 4 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
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) Lincoln, Illinois.

FATHER 13. NAME Kames Wyse
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shamokin Pa.

MOTHER 15. MAIDEN NAME Edna McShane
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Holland Illinois.

17. INFORMANT (ADDRESS) Mrs. J. Wyse Lincoln Illinois.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lincoln Ill DATE 6/27/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Honpe 4700 Washington Blvd.

20. FILED JUN 25 1939 GR Meyer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-24, 1939
22. I HEREBY CERTIFY, That I attended deceased from May 29, 1939, to June 24, 1939
I last saw ER alive on June 24, 1939. Death is said to have occurred on the date stated above, at 5:35 A.M.
The principal cause of death and related causes of importance were as follows:

Bilateral Bronchiectasis Date of onset 12 years
Hemorrhage from pulmonary artery 1 day
Other contributory causes of importance: 106 lb

Name of operation Subtotaly Date of 6/6/39
What test confirmed diagnosis? Clinical 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) James E. Mudd, M. D.
(Address) 634 N. Grand Blvd

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.

9/6
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2

50M-9-19-38 I X16803

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 Albert G. Hoppa
Licensed Embalmer No. 2971
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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

23266
Do not use this space.

1. PLACE OF DEATH *St Louis*

(a) County *St Louis* Registration District No. *784*

(b) Township *Richmond* Primary Registration District No. *111*

(c) City *Richmond* (d) Street No. _____ St. _____

(e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number)

yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Jane McHyene Marks*

(a) Residence, No. _____ 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *W* (write the word)

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

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

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

15 4 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

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) _____

FATHER 13. NAME *Kame wye Marks*

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

MOTHER 15. MAIDEN NAME *Edna McPherson*

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED *6-25 1939* *J R Meyer* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-24 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 _____ stated above, at _____ m.

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

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) *James L. Mudd* M. D. (Address) _____

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.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

