DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D AUG 11 1939

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23954

Primary Registration District No.

Registrar's No. 6227

1003

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3415 Delmar Blvd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 74 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

21

(d) Street No. 3415 Delmar
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MARY LAND 0530

3. (b) If veteran, name war /

3. (c) Social Security No. /

4. Sex Femal

5. Color or race White

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~

6. (b) Name of husband ~~or wife~~ Chas Lando

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 29 (Day) 1865 (Year)

8. AGE: Years 74 Months 1 Days 14 If less than one day hr. min.

9. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)

10. Usual occupation Nihil 9

11. Industry or business " 9

FATHER
12. Name John Tenuick 9
13. Birthplace Dont Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jane Scott
15. Birthplace Dont Know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edna Boyer
(b) Address 3415 Delmar

17. (a) Calvary Cem (Burial, cremation, or removal) (b) Date thereof 7/15/39 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John P Collins & Bro
(b) Address 928 N Grand Blvd

19. (a) JUL 14 1939 (Date received local registrar) (b) J F Rosebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-12 day year 39 hour 5 PM minute — M.

21. I hereby certify that I attended the deceased from 7-1-39, 1939, to 7-12, 1939 that I last saw her alive on 7-11, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Interstitial Nephritis	2 year
Due to	
Due to	
Other conditions Arterio Sclerosis. (Include pregnancy within 3 months of death)	1 year
Major findings: Of operations —	
Of autopsy no	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury /

23. Signature J. W. Macdonald (M. D. ~~[illegible]~~)
Address 539 N Grand Date signed 7-14-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

I X19511

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 H. Kampe

Licensed Embalmer No. 1861

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.