

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.

ADD 11 1938
ISOLATION HOSPITAL

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

24038
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... 791
(b) Township..... Primary Registration District No..... 1008
(c) or City... St. Louis, Mo...... (d) Street No..... Isolation 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 6 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 4417 1/2 Elmbank 3 St. 10 (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 (OR) WIFE OF Lawrence Kintz

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 20, 1914

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 7 27

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

FATHER 13. NAME A. J. Deering

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Illinois

MOTHER 15. MAIDEN NAME Nellie Comrack

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Illinois

17. INFORMANT (ADDRESS) Mr. Lawrence Kintz 4417 1/2 Elmbank St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Marion Ill DATE July 19, 1938

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

20. FILED JUL 17 1938 J. F. Bredich Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from April 18, 1939 to July 17, 1939

I last saw her alive on July 17, 1939 at 7:00 a.m. Death is said to have occurred on the date stated above, at 7:00 a.m.

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

Pulmonary tuberculosis Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... 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 Yes (Signed) W. M. as w. M., M. D.
(Address) 5600 Arsenal St., 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 Guy W. Wilkinson
Licensed Embalmer No. 3575
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.