

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24394

REC'D AUG 11 1939 791

Registration District No. 1003

Primary Registration District No. _____

Registrar's No. 6667

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo - 6 days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 2113 No. 10th Str.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Lettie Kaiser 260
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 29
year 1939 hour 12:55 minute _____ P. M.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Fred 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from 6/23/39
_____, 19____, to 7/29, 1939
that I last saw her alive on 7/29, 1939
and that death occurred on the date and hour stated above.

7. Birth date of deceased June 29, 1884
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Cervix uteri. Duration _____

8. AGE: Years Months Days If less than one day
55 0 0 hr. _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

9. Birthplace Washington Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name James Stears
13. Birthplace Washington Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Ema Johnson
15. Birthplace Washington Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Alice Risk
(b) Address 2113 N. 10th St.

17. (a) Burial (b) Date thereof 8-1-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director A. Kron Und., Co.
(b) Address 2707 N. Grand Blvd.

19. (a) JUL 31 1939 (b) J. D. [Signature]
(Date received local registrar) (Registrar's Signature)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury !
23. Signature M. A. Casberg (M. D. or other) _____
Address City Hospital Date signed _____

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.

Em blank signed CF

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.