

REC'D SEP 14 1939

791
1008

STANDARD CERTIFICATE OF DEATH

State File No.

27514

7014

Registration District No.

Primary Registration District No.

Registrar's No.

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: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
 (c) City or town Harrisburg [NR]
 (If outside city or town limits, write "RURAL")
 (d) Street No. B. R. # 2
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Verba Pickering 265

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive unkn years

7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE: about 50 Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Ward

13. Birthplace Ill
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Pickering

(b) Address Rd #2 Harrisburg Mo

17. (a) Removed (b) Date thereof 08-12-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrisburg Ill

18. (a) Signature of funeral director: Gilbons Funeral Home

(b) Address Harrisburg Ill

19. (a) AUG 12 1939 (b) _____
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12
 year 1939 hour 4 minute 10 A. M.

21. I hereby certify that I attended the deceased from 8-10, 1939 to 8-12, 1939
 that I last saw her alive on 8-12, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis femo. Duration _____

Due to Squamous Cell Carcinoma of uterus spec. _____

Due to Primary site uterus spec. _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Multiple metastases of carcinoma
 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address BARNES HOSPITAL Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
 1 x 11 1/2

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 Howard A. Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis, Mo

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.