

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
1939 CENSUS
1939 SEP 7 1939

State File No. 30183
Registrar's No. 1518

Registration District No. 784

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town W. Over - Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 2 yrs, 4 mo, 4 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 367 W. Tesson St.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME LORRAINE MARTIN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased 3 19 1919
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 5 6 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Edward Martin 1

13. Birthplace Chester, Ill 0
(City, town, or county) (State or foreign country)

14. Maiden name Rose Edell

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

16. (a) Informant's own signature Robert Koch Hospital

(b) Address _____

17. (a) Burial (b) Date thereon Aug 28-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marcellus

18. (a) Signature of funeral director Frank J. Wald

(b) Address 1420 W. Tesson St.

19. (a) AUG 26 1939 (b) W. J. Wald
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 25
year 1939 hour 1 minute 55 M.

21. I hereby certify that I attended the deceased from 4
21, 1939, to 8-25, 1939
that I last saw her alive on 8-25, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 1933
Duration _____

Due to _____

Due to 23

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

Major findings: Of operations _____

Of autopsy Pulmonary Tbc Intestines, etc

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 L. J. Glance (M. D. or other)

Address Robert Koch Hospital Date signed 8-25-39

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.....

Oliver Fendler....., Registered Apprentice No. *186*
working under my personal supervision.

Signed *Wilson Gallin*.....
Licensed Embalmer No. *3887*
P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.