

REC'D OCT 11 1939 791

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **8176**

1. PLACE OF DEATH: **1003**

(a) County _____ 1

(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **MISSOURI BAPTIST**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 DAYS**
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____ 1

(c) City or town **ST LOUIS** **5**
(If outside city or town limits, write "RURAL")

(d) Street No. **5834 WEST MINISTER**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **21**
year **1939** hour **2** minute **35 P** M.

21. I hereby certify that I attended the deceased from **Sept 15**, 19**39**, to **Sept 21**, 19**39**;
that I last saw her alive on **Sept 21**, 19**39**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Bronchitis**

Due to _____

Due to _____

Other conditions **Chronic Myocarditis**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically

3. (a) PRINT FULL NAME **IDA LAIRD 1.30**

3. (b) If veteran, name war _____

3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **DOCTOR ? LAIRD**

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

7. Birth date of deceased **UNKNOWN 1856**
(Month) (Day) (Year)

8. AGE: Years **abt 83** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **ST LOUIS MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE** **0**

11. Industry or business **HOME** **0**

12. Name **THOMAS HITES** **0**

13. Birthplace **UNKNOWN MISSOURI**
(City, town, or county) (State or foreign country)

14. Maiden name **ELIZABETH TONZEY**

15. Birthplace **UNKNOWN MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Raymond Hites**

(b) Address **47056 BONITA**

17. (a) **BURIAL** (b) Date thereof **9-23-39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FEE FEE**

18. (a) Signature of funeral director **Cullen & Kelly**

(b) Address **1416 N. Taylor Ave.**

19. (a) **SEP 22 1939** (b) _____
(Date received by Registrar) (Registrar's Signature)

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 **H A Uhlermeyer** (M. D. or other) _____
Address **1511 E Grand Bl** Date signed **9/23/39**

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.

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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.....

Mark L. Leinon

....., Registered Apprentice No. *174*

working under my personal supervision.

Signed *Clement McNeary*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.