31419

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791 (REC'D OCT 14 1939) 1003

Primary Registration District No. _____

Registrar's No. 8182

1. PLACE OF DEATH: 1

(a) County _____

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

(c) Name of hospital or institution: FERMIN DESLOGE HOSP (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

In this community yes

2. USUAL RESIDENCE OF DECEASED: 1

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town NORMANDY NR (If outside city or town limits, write "RURAL")

(d) Street No. 7661 Florissant Road (If rural, give location)

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

3. (a) PRINT FULL NAME SARAH MESNIER 256

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 WIDOWED

6. (b) Name of husband or wife GEORGE MESNIER

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

7. Birth date of deceased JULY (Month) 14 (Day) 1870 (Year)

8. AGE: Years 69 | Months 2 | Days 6 | If less than one day ___ hr. ___ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name CHAS. W. POUND
13. Birthplace — (City, town, or county) ENGLAND (State or foreign country)

MOTHER
14. Maiden name WINNIE TURNER
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature Mrs. [illegible] Flesh

(b) Address 2955 S. Kingshighway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Old Picker Cemetery

18. (a) Signature of funeral director L. B. Tanner

(b) Address 6437 Natural Bridge Rd

19. (a) SEP 23 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20 year 1939 hour 1 minute 50 P. M.

21. I hereby certify that I attended the deceased from Sept 17, 1939, to Sept 20, 1939 that I last saw h. or alive on Sept 20, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Shock following Operation	1 day
Due to Carcinoma Ovary	2
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Carcinoma of Ovary	

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature William H. Vogt (M. D. or other)

Address 330 Metropolitan Bldg Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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.....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 wit the above constitutes grounds for revocation of license.)

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