

791
1008

Registration District No. **1008** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **City Hospital # 1**
(d) Length of stay: _____

NOV 13 1939

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **3515 Evans Ave.**
(e) If foreign born, how long in U. S. A. _____ years.

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In this community _____ years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Mabel Kee**

3. (b) If veteran, name war _____ 3. (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 **Prentice Kee** 6. (c) Age of husband or wife if alive **50** years

7. Birth date of deceased **Oct. 10 1891**
(Month) (Day) (Year)

8. AGE: Years **48** Months **0** Days **5**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Dont Know**

13. Birthplace **Dont Know**
(City, town, or county) (State or foreign country)

14. Maiden name **Dont Know**

15. Birthplace **Dont Know**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Prentice Kee**

(b) Address **3515 Evans Ave 10 17 39**

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Cullinane Bros.**

(b) Address **1710 N. Grand Bl.**

19. (a) **OCT 17 1939** (b) **J. B. Buckner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **15th.** year **1939** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of uterus malignant**

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

Major findings: Of operations _____
Of autopsy _____

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)
23. Signature **Alfred Perry** (M. D. or other) _____
Address **Reynolds** Date signed **10.17.39**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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

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.

Rev. 5-17-39
1-11-39

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 Fred Frick

Licensed Embalmer No. 3186

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.