

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 9333

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH: 1003

(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: Firmin Desloge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 weeks
 (Specify whether _____)
 In this community 12 yrs
 (years, months or days)

8. (a) PRINT FULL NAME Cloie Johns 52.08. (b) If veteran, name war no 8. (c) Social Security No. none4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife Pete 6. (c) Age of husband or wife if alive 50 yrs
years7. Birth date of deceased Feb. 22, 1904
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
35 8 8 hr. min9. Birthplace Camden, Tenn
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name Kit Walker13. Birthplace Camden Tenn
(City, town, or county) (State or foreign country)14. Maiden name Frontie Hargis
(City, town, or county) (State or foreign country)15. Birthplace Camden, Tenn.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Thomas Johns(b) Address Thos. Johns17. (a) Removal (b) Date thereof 10/31/39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Paris, Tenn,18. (a) Signature of funeral director W. H. McLaughlin(b) Address 2301 Lafayette Ave19. (a) OCT 31 1939 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 18
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2929 Park Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30 h
year 1939 hour 3 minute 30 P. M.21. I hereby certify that I attended the deceased from 9/1
_____, 1939, to 10/30, 1939that I last saw her alive on 10/30, 1939
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma of Uterus Duration
Generalized MetastasisDue to Bilateral Pyelonephritis due
Carcinoma at lower Ureters

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: Pyelonephritis
Of operation _____Of autopsy As Above

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 J. F. Budick (M. D. or other) _____Address 13950 So. Grand Date signed 10/30/39

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 Paul A. Keith

Licensed Embalmer No. 3612

P. O. Address 2301 Lafayette

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.