

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
DEC 13 1939 791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37731  
9570  
Registrar's No.

Registration District No. 1000 Primary Registration District No.

1. PLACE OF DEATH: 1  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution: DePaul Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1  
(a) State Missouri (b) County ST. LOUIS  
(c) City or town St. Louis PINE LAWN N.R.  
(d) Street No. 6242 Dardenella  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Daisey Dundore 531  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Aaron 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July 14 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 3 24 hr. min.

9. Birthplace Cincinnati Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Wilmer Spicer  
13. Birthplace Kentucky 9  
14. Maiden name Unknown Dunne  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gladys Prior  
(b) Address 6242 Dardenella

17. (a) Removal (b) Date thereof 11/9/39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chicago, Ill.

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Ave

19. (a) NOV 9 1939 (b) J. F. Bedeck  
(Date of medical registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8 th  
year 1939 hour 7:45 minutes P. M.

21. I hereby certify that I attended the deceased from 11/1/39  
\_\_\_\_\_, 19\_\_\_\_, to 11/8/39, 19\_\_\_\_;  
that I last saw her alive on Nov 8, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 days  
R

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Arterial occlusion (emboly) Pt.  
(Include pregnancy within 3 months of death)

Major findings: occlusion of Rt. femoral artery  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 W. J. Wilson (M. D. or other)  
Address 6242 Dardenella St. Louis Date signed 11/9/39

REV. 5-17-39  
1 X19511

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed J. G. Sullivan  
Licensed Embalmer No. 1122  
P. O. Address.....

**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.**