

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
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37964**
Registrar's No. **9802**

Registration District No. **701** Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County **1**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Christian Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Minnie Isgrig 267**
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 **Stanley M. Isgrig** 6. (c) Age of husband or wife if alive **61** years
7. Birth date of deceased **Oct. 19 1880**
(Month) (Day) (Year)

8. AGE: Years **59** Months **0** Days **25** If less than one day _____ hr. _____ min.

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

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **T. J. McFarland**

18. Birthplace **Mo!** (City, town, or county) (State or foreign country)

14. Maiden name **Fannie Gold**

15. Birthplace **N.Y.** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Stanley M. Isgrig**

(b) Address **4637 Pope Ave**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-20-39** (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Arthur H. Harnal**
(b) Address **2905 Union Blvd.**

19. (a) **NOV 17 1939** (Date received and registered) (b) **J. D. Busdeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **9**
(d) Street No. **4637 Pope Ave.** (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **16** year **1939** hour **12** minute **22 p** M.
21. I hereby certify that I attended the deceased from **November 4**, 19**39**, to **Nov. 16**, 19**39**; that I last saw her alive on **Nov. 16**, 19**39**; and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy** Duration _____

Due to _____
Due to _____
Other conditions **Hypertension** (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) (e) Means of injury _____

23. Signature **J. A. Whitemeyer** (M. D. or other) **9/1/39**
Address **1511 E Grand St** Date signed **11/17/39**

1507 St. W. Leonard
9-11-22

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.....

R. M. Sanford

Licensed Embalmer No. 2273

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.