

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

REV. 6-17-39
 1-1 X18511

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. 38165
 Registrar's No. 10004

Registration District No. 701 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County 1
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 (Specify whether years, months or days) 65 years

3. (a) PRINT FULL NAME MINNIE JANE GRIBBLE 614

8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife wife 6. (c) Age of husband or wife if alive unknown years
 7. Birth date of deceased Feb 2 1864
 (Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 20 If less than one day hr. min.

9. Birthplace Colchester Del.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business

12. Name unknown 9

13. Birthplace unknown 9
 (City, town, or county) (State or foreign country)

14. Maiden name unknown
 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. Karl Gribbler

(b) Address 8405 N. Broadway

17. (a) Burial (b) Date thereof Nov 25 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zions Cem.

18. (a) Signature of funeral director H. Leidner

(b) Address 1417 N. Market St.

19. (a) NOV 23 1939 (b) J. P. Bredish
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St. Louis 8
 (If outside city or town limits, write "RURAL")
 (d) Street No. 8405 North Broadway
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
 year 1939 hour 11 minute 35 A.M.

21. I hereby certify that I attended the deceased from November 12, 1939, to November 22, 1939;
 that I last saw her alive on November 22, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage Duration
Cerebral Aneurysm
Myocardial Infarction
 Due to 8:00
 Due to 8:00
 Other conditions Typhoid Pneumonia
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy as above
 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 O. M. Anderson (M. D. or other) M.D.
 Address BARNES HOSPITAL Date signed 11-22-39

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 Homer L. Ponder
Licensed Embalmer No. 3367
P. O. Address 2223 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.