

38240

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

10079

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 13 1939 791

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4564 Cote Brilliante Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community About 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4564 Cote Brilliante Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Luvenia Whitten 350

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife John Whitten 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 30, 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 0 21 _____ hr. _____ min.

9. Birthplace Iberry Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name George Lennox 9

13. Birthplace Unavailable 0
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Allen

15. Birthplace Iberry Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arthur Foster

(b) Address 3522 Hawthorn Avenue

17. (a) Burial (b) Date thereof 11/26/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Bank

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) NOV 26 1939 (b) J. F. Buechler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21,
year 1939 hour 7:00 minute 45 P. M.

21. I hereby certify that I attended the deceased from 11/14, 1939, to 11/21, 1939
that I last saw her alive on November 21, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Disease

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 Leo Concessionary (M. D. or other) 39
Address 1701 North Whittier Date signed 11-22-

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.

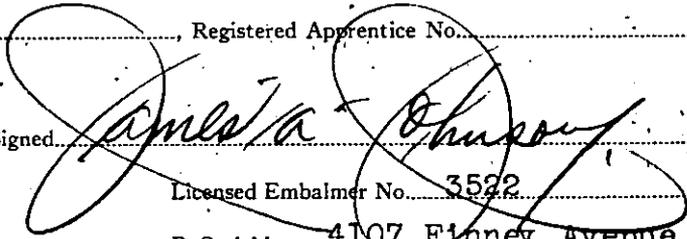
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

working under my personal supervision.

....., Registered Apprentice No.

Signed 

Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Avenue,**

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.