

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

38338

State File No. _____

Registrar's No. _____

10172

 REGISTRATION DISTRICT NO. 30
 DEC 13 1939

Primary Registration District No. _____

1. PLACE OF DEATH: /

(a) County _____
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital, #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Stillborn
 (Specify whether _____)
 In this community Stillborn
 years, months or days

 3. (a) PRINT FULL NAME Bean, Baby 5m

 3. (b) If veteran, name war X 3. (c) Social Security No. X

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

 6. (b) Name of husband or wife. X 6. (c) Age of husband or wife if alive X years

 7. Birth date of deceased October 29, 1939
 (Month) (Day) (Year)

 8. AGE: Years Months Days If less than one day
Stillborn hr. min.

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

 10. Usual occupation X 0

 11. Industry or business X

 12. Name James Bean

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

 14. Maiden name Mamie Falls

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

 16. (a) Informant's own signature Ann Morrison

 (b) Address City Hospital, #1

 17. (a) Burial (b) Date thereof 11-28, 39
 (Burial, cremation, or removal) (Month) (Day) (Year)

 (c) Place: burial or cremation City of St. Louis

 18. (a) Signature of funeral director Edith Van Tappan

 (b) Address City of St. Louis

 19. (a) NDV 29 1939 (b) J. F. Bealack
 (Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED: /

(a) State Missouri (b) County X
 (c) City or town St. Louis, //
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3853 Evans
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

 20. DATE OF DEATH: Month October day 29,
 year 1939 hour 9:50 minute A. M.

 21. I hereby certify that I attended the deceased from October 29, 19 39 to October 29, 19 39;
 that I last saw her alive on October 29, 19 39
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Stillborn

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 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? 1 (Specify type of place) (c) Means of injury _____

 23. Signature Marcelle W. Kelly (M. D. or other) _____
 Address 1515 Lafayette, 10-31-39 Data signed _____

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.....

Licensed Embalmer No.....

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.