

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

Form 8-17-39
U.S. GOVERNMENT PRINTING OFFICE: 1938

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. 38407
Registrar's No. 10246

Registration District No. 201 Primary Registration District No. _____

1. PLACE OF DEATH: 1003
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days
(Specify whether _____)
In this community _____
years, months or days)

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

3. (a) PRINT FULL NAME Reynolds Medart 363
3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 30
year 1939 hour 1:15 minute 4 M.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 27, 1939
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from birth to 1939;
that I last saw him alive on Nov 28, 1939,
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
0 0 3 hr. _____ min.

Immediate cause of death St. Louis hemorrhagic meningitis, granis 2 1/2 days
Duration _____

9. Birthplace St. Louis Mo.
(City, town or county) (State or foreign country)
None

Due to Cerebral
Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

11. Industry or business _____
12. Name Reynolds Medart
13. Birthplace St. Louis Mo.
14. Maiden name Josephine Brinkwirth
15. Birthplace St. Louis Mo.
(City, town or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy confirmatory of above diagnosis
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Reynolds Medart
(b) Address Overhills Drive
17. (a) Burial (b) Date thereof 11-30-1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Celvary
18. (a) Signature of funeral director Arthur J. Donnelly
3840 Lindell Blvd.
(b) Address NOV 30 1939
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 P. J. Phelps (M. D. or other) _____
Address 3720 Leaning Tower Date signed 11/30/39

Dr. Police Hospital

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 *Stanley Marshall*
Licensed Embalmer No. *2868*
P. O. Address *3840 Lindell*

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.