DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 40053

Registration District No. 441 | Primary Registration District No. 4259 | Registrar's No. 68

**1. PLACE OF DEATH:**

(a) County KNOX 2

(b) City or town Edina
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: South East Edina.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution [illegible] (Specify whether years, months or days)

In this community Edina, Mo. 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:** 1

(a) State Missouri. (b) County Knox.

(c) City or town Edina.
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Laura Bell St Johns. 5[illegible]

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

4. Sex F | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Dr. Horas St. Johns. | 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased January (Month) 16. (Day) 1866 (Year)

8. AGE: Years 73 | Months 10 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Newtown. (City, town, or county) Indiana. (State or foreign country)

10. Usual occupation House Keeper.

11. Industry or business

FATHER
12. Name Jowel Jones.
13. Birthplace Newtown. (City, town, or county) Indiana. (State or foreign country)

MOTHER
14. Maiden name Carrie Hall.
15. Birthplace Knox City. (City, town, or county) Missouri. (State or foreign country)

16. (a) Informant's own signature Emma Bondurant
(b) Address Edina Mo

17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec- 2-1939 (Month) (Day) (Year)
(c) Place: burial or cremation Labelle Mo.

18. (a) Signature of funeral director Keith Hudson
(b) Address Edina Mo.

19. (a) Dec 2 1939 (Date received local registrar) (b) Mrs C M Smith (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day ~~28~~ 30 year 1939 hour 2 minute — A. M.

21. I hereby certify that I attended the deceased from Nov. 26, 1939, to Nov. 28, 1939, that I last saw her alive on Nov 27, 1939 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Bronchial Pneumonia | 2 days |
| Due to Chronic Nephritis | |
| Due to Poison in System From infected Teeth | |
| 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? (Specify type of place)
While at work? — (e) Means of injury ____

23. Signature F. E. Lumaee (M. D. ~~or other~~)
Address Edina Mo Date signed Dec 2/39

3 5 (Licensed Embalmer's Statement on Reverse Side)

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 stat CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importar

I X19511

RECEIVED
District Health Officer No. 10
District File Number 12-39-2043
Date Filed DEC 5 1939

## 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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina Mo.

**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.**

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

40053
Do not use this space.

1. PLACE OF DEATH
(a) County: Knox
(b) Township:
(c) City: Edina
Registration District No.: 441
Primary Registration District No.: 4259
Registered No.:
(d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred: yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Laura Belle St John
(a) Residence, No.: St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Dr Horace St Johns

6. DATE OF BIRTH (MONTH, DAY, AND YEAR):

7. AGE: Years 73 | Months 10 | Days 14 | If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.:
9. Industry or business in which work was done, as saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

FATHER
13. NAME:
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

MOTHER
15. MAIDEN NAME:
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

17. INFORMANT (ADDRESS):

18. BURIAL, CREMATION, OR REMOVAL
PLACE: DATE: 19

19. FUNERAL DIRECTOR (ADDRESS):

20. FILED Feb 16, 1940 Mrs C M. Smith
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Nov 6 1939

22. I HEREBY CERTIFY, That I attended deceased from 19.... to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| | |
| | |
| | |
| | |
| | |

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) F. E. Lemmon, M. D.
(Address) Edina Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW