

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 1339 784

Primary Registration District No. 10

Registrar's No. 2059

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 18 days
15 years. (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME Nancy McInnis 252
 3. (b) If veteran, name war _____ 3. (c) Social Security No. ?

4. Sex female 5. Color or race colored 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife George McInnis 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan. 1 1880
 (Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace ? Miss. 1
 (City, town, or county) (State or foreign country)

10. Usual occupation W.P.A.

11. Industry or business sewing project

MOTHER FATHER {
 12. Name Sam Evans
 18. Birthplace Enterprise Miss.
 (City, town, or county) (State or foreign country)
 14. Maiden name Amelia Washington
 15. Birthplace ? Ala.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ethel Lee Rogers
 (b) Address Scudder & Lix St. Kinloch Mo

17. (a) _____ (b) Date thereof 11-21-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park

18. (a) Signature of funeral directors Boyd Bros.
 (b) Address 614 S. 1st St. St. Louis Mo

19. (a) NOV 25 1939 (b) D. R. Meyer, M.D. D.P.H.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. 1 (b) County St. Louis
 (c) City or town S. Kinloch
 (If outside city or town limits, write "RURAL")
 (d) Street No. Scott and Lix
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21
 year 1939 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from 11-3-39
 _____, 19____, to 11-21-39, 19____;
 that I last saw her alive on 11-21-39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Colloid Cd of Rectum and Peritonitis Duration 1 yr 7 mo

Due to Peritonitis 4/6

Due to Breakdown of operators wound 5 days

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

Major findings: Multiple pelvic adhesions
Colloid Cd of Rectum
 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? _____ (Specify type of work)
 (e) Means of injury _____

23. Signature Beck Johnston (M. D. or other) _____
 Address St. Louis, Mo Date signed 11-21-39

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.....

Licensed Embalmer No. 2842

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.