

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.

JAN 12 1940

791

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH: **10083**
(a) County **St. Louis,** **2**
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5137 Northland Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50 Years.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **St. Louis,** **L**
(If outside city or town limits, write "RURAL")
(d) Street No. **5137 Northland Ave. m**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Sarah Doza.,** **200**
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **1,**
year **1939** hour **6** minute **50 P. M.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife **Jesca** 6. (c) Age of husband or wife if alive **unknown** years

21. I hereby certify that I attended the deceased from **December 6,** 19**38** to **Dec 1,** 19**39**; that I last saw her alive on **November 30,** 19**39**; and that death occurred on the date and hour stated above.

7. Birth date of deceased **Oct. 23** **1867**
(Month) (Day) (Year)
8. AGE: Years **72** Months **1** Days **8** If less than one day _____ hr. _____ min.

Immediate cause of death **Hyperthyroidism** **1 year**
Duration

9. Birthplace **Illinois.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housework**

Due to **Chronic Myocarditis** **6 mo.**
Other conditions (include pregnancy within 3 months of death)

11. Industry or business
MOTHER FATHER { 12. Name **Jefferson Gendron.** **4**
13. Birthplace **Unknown.** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Page.**
15. Birthplace **Unknown.** (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Jesca M. Doza.**
(b) Address **5137 Northland Ave.,**
17. (a) **Burial** (b) Date thereof **12-5-39.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cem.**
18. (a) Signature of funeral director **My Leidner M. Co.**
(b) Address **1417 N. Market Street.**
19. **DEC 3 1939** (b) **J. F. Brudick**
(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 **1**
23. Signature **Allen H. Roe MD** (M. D. or other) **1**
Address **2712 a N. 14th** Date signed **12/2/39**

Dr. Roe 1-3.

2714 N. 14th St.

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis

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.