

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 201

Primary Registration District No. _____

Registrar's No. 10476

1. PLACE OF DEATH: 1003

(a) County _____

(b) City or town St. Louis

(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Baby Robt. Marion Wynn 501

3. (b) If veteran, name war No

3. (c) Social Security No. None

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 Dec. 5, 1939
(Month) (Day) (Year)

8. AGE: Years 00- 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 _____

11. Industry or business _____

MOTHER FATHER { 12. Name Richard Wynn

18. Birthplace Bismarck, Mo.
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name The Sherrill

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

16. (a) Informant's own signature Richard Wynn

(b) Address 3502 S. Jefferson Ave

17. (a) Burial Bismarck, Mo.
(Burial, cremation, or removal)

(b) Date thereof 12/7/39
(Month) (Day) (Year)

(c) Place: burial or cremation Bismarck, Mo.

18. (a) Signature of funeral director R. Th. McQuinn

(b) Address 2301 Lafayette Ave

19. (a) Dec 7 1939
(Date received local registry)

J. S. [Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 24
(If outside city or town limits, write "RURAL")

(d) Street No. 3502 S. Jefferson
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec. 5, day 11:45 P.
year 1939 hour _____ minute _____

21. I hereby certify that I attended the deceased from Aug 2
1939 to Dec 5 1939

that I last saw her alive on Dec 5 1939
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Eclampsia
Stillborn
Acute atrophy of liver

Due to _____

Due to _____

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

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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 place)

(1) Means of injury _____

23. Signature Frank J. Schroy, M.D.
Address 2800 [Address] Date signed 12.7.39

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.

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 *L. W. Cooper*.....

Licensed Embalmer No. *3633*

P. O. Address *2317 K. Gaylett*

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.