

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

41395

State File No. _____

AN 12 17 1939

Registration District No. 0000

Primary Registration District No. _____

Registrar's No. 10518

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital, #1
 (If not in hospital or institution, write street number of location)
 (d) Length of stay: In hospital or institution 4 Days
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Carrie Hughes 220
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife unknown
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 16 1863
 (Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 19
 If less than one day hr. _____ min. _____

9. Birthplace Youngstown Ohio
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Julian A. Laurent, 7
 13. Birthplace Alsace Loraine 1
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Eirlbin
 15. Birthplace Pennsylvania
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. F. Hughes
 (b) Address 426 De Bevoise

17. (a) Burial (b) Date thereof 12-9-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lakewood Park Cem.

18. (a) Signature of funeral director Cullinane Bros.
 (b) Address 1710 N. Grand Blvd.

19. (a) DEC 8 1939 (b) J. P. [Signature]
 (If received local registrar) (If registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis 27
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3610 Missouri Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 5,
 year 1939 hour 10:00 minute _____ P. _____ M.
 21. I hereby certify that I attended the deceased from December 2, 1939 to December 5, 1939
 that I last saw her alive on December 5, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Thrombosis
Myocardian
Differential Myocarditis
Chronic Myocarditis
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

Duration _____
 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 place) (e) Means of injury _____
 28. Signature J. P. [Signature] (M. D. or other) MD
 Address 1515 Lafayette, 12/6/39
 Date signed

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

Fred Frick

Licensed Embalmer No. *3186*

P.O. Address

St. Louis 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.