

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41714
Registrar's No. 10837

Registration District No. 1000 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____ 2
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1521 B. Cora
(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

8. (a) PRINT FULL NAME Mary Jones
8. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race Col. 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 May 11 1856
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Cold Water Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Thomas

12. Name _____

13. Birthplace Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Isura Ingram
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mary Price

(b) Address 1521 B Cora

17. (a) Burial (b) Date thereof 12 - 23 - 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Mary Wade

(b) Address 420 E. Genessee Ave

19. (a) DEC 19 1939 (b) _____
(Date received local Registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1521 B Cora Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19 year 1939 hour 10 minutes 15 M.
21. I hereby certify that I attended the deceased from Sept 15 1938 to Dec 17 1939
that I last saw him alive on Dec 18 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis
Progressive
Malignant
Due to Carbuncle of the Rectum

Due to _____
Other conditions 46
(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 _____
23. Signature J. E. ... (M. D. or other)
Address 420 E. Genessee Ave Date signed _____

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.....

.....
Licensed Embalmer No. 2695

P. O. Address.....
2769 Chauld

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *417147*

Registrar's No. *10837*

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... *St. Louis*
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(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..... *Mary Jones*
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex *F* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *w*
 6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 12. Name.....
 13. Birthplace.....
(City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a) *6-3-40* (b) *J. J. Bredeck*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(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.

20. DATE OF DEATH Month *12* - day *19* - year *39*
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
 19..... to..... 19.....
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Paralysis progressive
 Due to *Malignant (not cancer)*
Carbuncle of rectum
 Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations..... *82 d.*
 Of autopsy.....

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.

23. Signature *Wm H. Perry* (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

