

JAN 12 1940 **701**
Registration District No. **1000**

Primary Registration District No. _____

1. PLACE OF DEATH: **1**
(a) County _____
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution: **City Hospital, #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 Days**
(Specify whether _____)
In this community: **Unknown**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **13**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **X** years.

3. (a) PRINT FULL NAME **Dora Niner** **560**
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **27**,
year **1939** hour **8:30** minute _____ P. M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive **X** years
7. Birth date of deceased **June ?? 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **December 13, 1939** to **December 27, 1939**
that I last saw her alive on **December 27, 1939**
and that death occurred on the date and hour stated above.

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

Immediate cause of death **Bronchopneumonia (post-operative)** Duration **2 days**
Septicemia (Heart Disease)
Due to **Arteriosclerosis, General**
Gonorrhea, Leg. Left
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Major findings: **Aspiration (mid-thigh)**
Left Leg
Of autopsy **Bronchopneumonia**

10. Usual occupation **Nil.**

11. Industry or business **---**
MOTHER FATHER { 12. Name **John Niner**
13. Birthplace **UNKNOWN Missouri**
14. Maiden name **Unknown**
15. Birthplace **UNKNOWN Unknown**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature **Ann Morrison**
(b) Address **City Hospital, #1**
17. (a) **BURIAL** (b) Date thereof **1-2-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **CALVARY**
18. (a) Signature of funeral director **Cullen Kelly**
(b) Address **1416 N. TAYLOR**
19. (a) **DEC 31 1939** (b) _____
(Date received local health officer) (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 _____
23. Signature **L. Sawled** (M. D. or other) _____
Address **1515 Lafayette,** **12/28/39**

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 Raymond E. Gehlke, Registered Apprentice No. _____ working under my personal supervision.

Signed Raymond E. Gehlke
City St. Louis, Mo Licensed Embalmer No. 3985
#1, 80 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.