

364
 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 FILED FEB 17 1940
 REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S NO. 82
 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

State File No. 82
 Registrar's No. 82

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 28 Days
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Mo (b) County _____
 (c) City or town St Louis 5
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5724^{1/2} Labarre
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Olive Combs 512
 8. (b) If veteran, name war _____ 8. (c) Social Security No. X
 4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Chas. H. Combs 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Unknown
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 3, year 1940 hour 1:15 minute _____ P. M.
 21. I hereby certify that I attended the deceased from December 7, 1939, to January 3, 1940, that I last saw her alive on January 3, 1940, and that death occurred on the date and hour stated above.

8. AGE: Years about 60 Months _____ Days _____ If less than one day _____ hr. _____ min.
 9. Birthplace Mich (City, town, or county) (State or foreign country)
 10. Usual occupation at home
 11. Industry or business _____
 MOTHER FATHER { 12. Name Frank Murphy
 13. Birthplace unknown (City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace unknown (City, town, or county) (State or foreign country)

Immediate cause of death Syphilis of Central Nervous System Duration _____ years
 Due to _____
 Due to _____
 Other conditions Cystitis (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Bra Hemminger
 (b) Address 4640 Pag = 181
 17. (a) Burial (b) Date thereof 1-5-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthews Cemetery
 18. (a) Signature of funeral director Bra Hemminger
 (b) Address 4448 Washington Bldg
 19. (a) JAN 4 1940 (b) _____
 (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 _____
 23. Signature Walter Ford (M. D. or other)
 Address 1515 Lafayette Date signed 1/3/40

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 Philip M. Craig

Licensed Embalmer No. 32810

P. O. Address 4468 Washington

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.