

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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 621
Registrar's No. 621

Registration District No. 1002

Primary Registration District No.

1. PLACE OF DEATH: FILED FEB 17 1940
(a) County _____
(b) City or town ST. LOUIS
(c) Name of hospital or institution: ST. ANTHONY'S HOSPITAL
(d) Length of stay: In hospital or institution 4 days
In this community _____

3. (a) PRINT FULL NAME EMILIA S. VOYCE
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife CHARLES
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JUNE 30 1868

8. AGE: Years 71 Months 6 Days 21
If less than one day hr. min.

9. Birthplace ST. LOUIS, MISSOURI

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER
12. Name FRANK SIMMONS
13. Birthplace GERMANY
14. Maiden name CAROLINE SODERER
15. Birthplace GERMANY

16. (a) Informant's own signature _____
(b) Address 1106 Austin, Evanston, Ill
17. (a) burial (b) Date thereof 1/24/80
(c) Place: burial or cremation Bellefontain Cemetery

18. (a) Signature of funeral director _____
(b) Address 4016 Chippewa St.
19. (a) JAN 24 1940 (b) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(d) Street No. 4331 HARTFORD ST.
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JAN. day 21
year 1940 hour 3 minute 30 p. M.
21. I hereby certify that I attended the deceased from Oct 1939 to Jan 21 1940
that I last saw her alive on Jan 21 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Mediastinal abscess pulm.
Caused by bronchitis non-malignant
Due to Bronchiectasis and bronchitis
Due to Hypertensive encephalopathy
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy none performed

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(a) Means of injury _____
23. Signature J. J. Michael (M. D. or other) M.D.
Address 506 Olive Date signed 1/24/40

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 Ernest W. Spillars

Licensed Embalmer No. 4080

P. O. Address. 3528 Russell

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.