DEPARTMENT OF COMMERCE,
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4417

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 1247

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.

1. PLACE OF DEATH:

(a) County: 1

(b) City or town: St. Louis
(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 or location)

(d) Length of stay: In hospital or institution: 5 days (Specify whether years, months or days)

In this community: Unknown

2. USUAL RESIDENCE OF DECEASED:

0

(a) State: Missouri (b) County:

(c) City or town: St. Louis 10
(If outside city or town limits, write "RURAL")

(d) Street No.: 3937 Labadie Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: 530 Molly Lamothe

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: John Lamothe

6. (c) Age of husband or wife if alive: Deceased years

7. Birth date of deceased: January 15, 1875 (Month) (Day) (Year)

8. AGE: Years 65 | Months 0 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Louis (City, town, or county) — Missouri (State or foreign country)

10. Usual occupation: At home

11. Industry or business: 1

FATHER 12. Name: John Dixon

FATHER 13. Birthplace: (City, town, or county) — England (State or foreign country)

MOTHER 14. Maiden name: Agnes Mollankott

MOTHER 15. Birthplace: (City, town, or county) — Germany (State or foreign country)

16. (a) Informant's own signature: Helen Brinkmeyer

(b) Address: 3937 Labadie Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/8/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Bellefontaine Cem.

18. (a) Signature of funeral director: Math Hermann & Son

(b) Address: 2161 East Fair Ave

19. (a) FEB 7 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5th year 1940 hour 9:15 AM 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: Abscess of Gall Bladder, with stones; Pericarditis, with effusion; Arteriosclerosis.

Duration

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations:

Of autopsy:

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? (Specify type of place)

While at work? (e) Means of injury: 4

23. Signature: [signature] (M. D. or other)

Address: Deputy Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. 2967

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.