

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.

FILED APR 15 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

9037

Registrar's No.

2520

Registration District No.

791

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2829 THOMAS ST
(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 SALLIE JENKINS3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE4. Sex FEMALE 5. Color or race COL. 6. (a) Single, widowed, married, divorced WIDOW6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive NONE years7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
about 60 yrs hr. min.9. Birthplace ALABAMA
(City, town, or county) (State or foreign country)10. Usual occupation HOUSE WORK11. Industry or business AT HOME12. Name UNKNOWN ?13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)14. Maiden name CAROLINE HAMPTON ?15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Sallie Jenkins(b) Address 2829 Thomas St.17. (a) Removal (b) Date thereof 3-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Pineapple pla.18. (a) Signature of funeral director C. W. Roberts(b) Address 3035 Lucas Ave.19. (a) MAP 16 1940 (b) _____
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County _____
(c) City or town ST LOUIS 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2829 Thomas St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day Mar
year 1940 hour 10:20 minute P M.21. I hereby certify that I attended the deceased from Mar 3, 1940, to Mar 14, 1940
that I last saw her alive on Mar 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to apoplexy

Due to _____

Other conditions Sanity
(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: Natural
(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)
(a) Means of injury _____23. Signature J. D. Thurman (M. D. or other) _____
Address 2425 O 3 Alley Date signed _____

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 Arthur L. Ho, 11/2/11

Licensed Embalmer No. 3389

P. O. Address 3028 Jackson St

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.