

S. No. 2
-11-10-39
5-17-39
-I X21492

APR 15 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9199
Registrar's No. 2682

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2911 Laclede
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

8. (a) PRINT FULL NAME Alice Esters
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 9 4 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 17
If less than one day _____ hr. _____ min.

9. Birthplace Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Charles Scott
13. Birthplace Miss.
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Butterfly Poyner
(b) Address 2911 Laclede Ave

17. (a) Burial (b) Date thereof 3/22/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Russell Und. Co.
(b) Address 2732 Pine Street

19. (a) MAR 22 1940 (b) J. B. Buechler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2911 Laclede
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 16
year 1940 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb 13 1940 to March 16 1940
that I last saw her alive on March 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to Hypertension

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. A. Mueller (M. D. or other) M.D.
Address 2335 Franklin Date signed 3-20-40

Muller

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 *Joel Russell*
Licensed Embalmer No. *4112*

P. O. Address _____

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.