

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13161

State File No. _____

MAY 15 1940

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 3363

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1822 Coleman St 2
 (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 11
 (If outside city or town limits, write "RURAL")
 (d) Street No. # 1822 Coleman St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Kate Randolph 534

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 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 October 5 1863
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 6 7 hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9

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

14. Maiden name Unknown
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev Orlpha Linton

(b) Address 1822 Coleman St.

17. (a) Burial (b) Date thereof April 13 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Richardson Jones

(b) Address 1936 17 Loui Ave.

19. (a) APR 15 1940 (b) J. P. [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
 year 1940 hour 5:30 minute P M.

21. I hereby certify that I attended the deceased from March 10th
1940, to April 12, 1940
 that I last saw her alive on April 12 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis - Parenchymatous, Chronic Duration _____

Due to Myocarditis Chronic

Due to 131

Other conditions 131
 (Include pregnancy within 3 months of death)

Major findings: Of operations none
 Of autopsy none

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?

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

23. Signature M. Apsteres (M. D. or other) _____
 Address 2626 Glasgow St Date signed April 13

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.

I 11931

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 *[Signature]*
Licensed Embalmer No. *3737*
P. O. Address *1936 St. Louis*

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.