

FILED MAY 15 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

13241  
Do not use this space.

1. PLACE OF DEATH  
(a) County St. Louis Registration District No. 791  
(b) Township 0 Primary Registration District No. 1003  
(c) City St. Louis or (d) Street No. 4717 Thrush Ave Registered No. 3443  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JANE PINCOTT  
(a) Residence, No. 4717 Thrush St. 7 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Wm Pincott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 16 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
75 5 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

FATHER 13. NAME John Webb

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

17. INFORMANT (ADDRESS) Wm Pincott  
4717 Thrush

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter's DATE Apr 15 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peter A Ecker  
2849 N. Cicero

20. FILED APR 15 1940

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15<sup>th</sup> 1940

22. I HEREBY CERTIFY, That I attended deceased from March 22, 1940, to April 15, 1940.  
I last saw her alive on April 12, 1940. Death is said to have occurred on the date stated above, at 745 A.  
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis  
Date of onset unable to say  
Other contributory causes of importance None

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) Peter A Ecker \_\_\_\_\_, M. D.  
(Address) 4701 St Louis Ave

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.

Dr. Cook  
4701<sup>st</sup> Avenue  
Bellville

**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..... *Albert Mayfield*  
Licensed Embalmer No..... *287*  
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.**