

No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

23140

State File No. _____

REG AUG 25 1940
791

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 5585

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(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 1 Mo. 3 Days
(Specify whether _____)
In this community 50 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 915 Aubert
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME Alice Dodd

8. (b) If veteran, name war ---
8. (c) Social Security No. Unknown

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased September 30, 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>8</u>	<u>22</u>	hr. min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name George Mallory

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

14. Maiden name Bertha (Unknown)

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

16. (a) Informant A. Morrison
(b) Address City Hospital, #1

17. (a) _____ (b) Date thereof 6-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W. R. Rutter

(b) Address 3530 Lafayette

19. (a) JUL 1 1940 (b) J. F. Balbach
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21, year 1940 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from May 18, 1940, to June 21, 1940, that I last saw her alive on June 21, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Due to Renal Calculi (left)
Ureteral Calculi (left)

Other conditions 1/3/4
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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)
(a) Means of injury _____

23. Signature Robert B. Cooper (M. D. or other) _____
Address 1515 Lafayette Date signed 6/21/40

Duration

PHYSICIAN

Underlines the cause to which death should be charged statistically.

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

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. _____

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.