

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 OCT 25 1940

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

30650
Do not use this space.

1. PLACE OF DEATH
 (a) County Registration District No. 791
 (b) Township Primary Registration District No. 1003
 (c) City St. Louis (d) Street No. St. John's Hospital St. Registered No. 7927
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Judith Ellen Sewald
 (a) Residence, No. St. NR Crystal City Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug., 11., 1940

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>1</u>	<u>10</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

FATHER

13. NAME Andrew . Sewald

14. BIRTHPLACE (CITY OR TOWN) Farmington (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Lee Ellen Townsend

16. BIRTHPLACE (CITY OR TOWN) Potosi (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Andrew J. Sewald
Crystal City Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Festus Mo., DATE 9/23, 1940

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe (ADDRESS) 4700 Washington Ave.

SEP 23 1940 19 J. B. Breakley

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 22, 1940

22. I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1940, to Sept. 21, 1940. I last saw her alive on Sept. 20, 1940. Death is said to have occurred on the date stated above, at 1:00 P.M. about. The principal cause of death and related causes of importance were as follows:
Septicemia about
Early Bronchopneumonia
cause unknown
 Date of onset 9-20-40

Other contributory causes of importance: 107a

Name of operation none Date of operation

What test confirmed diagnosis? autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?, 19..... Date of injury, 19.....
 Where did injury occur?, 19.....
 (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

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify

(Signed) B. H. D. Small M. D.
 (Address) Crystal City, Mo.

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

Guy W Wilkerson

Licensed Embalmer No.....

3575

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.