DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33697

NOV 16 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8394

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.

1. PLACE OF DEATH:

(a) County

(b) City or town: St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3yr. 9mo. 17days (Specify whether years, months or days)

In this community 29 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town: St. Louis 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Emma Ferren

3. (b) If veteran, name war: Unknown

3. (c) Social Security No.: Unknown

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: Unknown (Month) Unknown (Day) 1896 (Year)

8. AGE: Years	Months	Days	If less than one day
abt. 44			hr. min.

9. Birthplace: Columbia (City, town, or county) Ill. (State or foreign country)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

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

16. (a) Informant's own signature: J. D. Sullivan

(b) Address: 5800 Arsenal St.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Oct 9, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: St. Matthews Cem.

18. (a) Signature of funeral director: John L. Siegenthaler & Sons

(b) Address: 7027 Gravois

19. (a) OCT 9 1940 (Date received local registrar) (b) J. F. Bradick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4 year 1940 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 23, 1940 to October 4, 1940 that I last saw her alive on October 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Geo. L. Bozzini M.D. (M. D. or other)

Address: City Infirmary Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 C. P. Kidwell

No Embalming

Licensed Embalmer No. 3877

P. O. Address 7027 Kravai's

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.