

No. 1-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILLED NOV 24 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32956
Registrar's No. 7908

Registration District No. 79

Primary Registration District No. 1003

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:
3533 Market St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 26 yrs
years, months or days)

3. (a) PRINT FULL NAME Hattie Vance

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

4. Sex Fem 5. Color or race Col 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife John Vance 6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased Abt. 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt. 74 hr. min.

9. Birthplace Selmer Tennessee /
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business at home

12. Name Jim Farr
13. Birthplace Selmer Tennessee /
(City, town, or county) (State or foreign country)

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

16. (a) Informant Robert R. Robinson
(b) Address 3719 Hickory Street

17. (a) Removal (b) Date thereof 10/3/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Selmer, Tennessee

18. (a) Signature of funeral director [Signature]
(b) Address 3517 Locust Ave

19. (a) OCT 3 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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. 3533 Market Street
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30th
year 1941 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Arteriosclerosis.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations [Signature]

Of autopsy [Signature]

Duration

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 Thomas J. Callahan (M. D. or other) _____
Address Deputy Coroner Date signed 10/1/41

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

209979

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.....

A. M. Shear

Licensed Embalmer No. *1173*

P. O. Address *3517 Soledad*

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, fact should be so stated above.