WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

I X12004

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

SEP 10 1937

29440
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 8073
(c) City St. Louis, Mo. (d) Street No. Central Hospital St.
(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 17 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Feen
(a) Residence, No. 3306 S. 13th St St. 24
(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): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Joseph Feen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug. 8, 1851

7. AGE: 26 — YEARS: 86 — MONTHS: 0 — DAYS: 18 — If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Nil
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) (STATE OR COUNTRY): Chillicothe Ohio

FATHER
13. NAME: Michal Brendal
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER
15. MAIDEN NAME: Mary Krammer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

17. INFORMANT (ADDRESS): William Roche 3306 S. 13th St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Cuba, Mo. DATE: 8/30/37, 19

19. FUNERAL DIRECTOR (ADDRESS): Edith E. Ambruster 4234 Manchester Ave.

20. FILED: AUG 27 1937 J. F. Bredeck, Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 8/26/37, 19

22. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1937 to Aug 26, 1937
I last saw her alive on Aug 26, 1937. Death is said to have occurred on the date stated above, at 645 p.
The principal cause of death and related causes of importance were as follows:

Carcinoma of Uterus with Metastasis in abdomen

Date of onset

Other contributory causes of importance:

Name of operation: None Date of
What test confirmed diagnosis? Was there an autopsy? no

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 —

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) John C Braun, M. D.
(Address) 4518 Washington Ave

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I, Florenz Eynck, Licensed Embalmer No. 1284

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed Florenz Eynck

Licensed Embalmer No. 1284

**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.)**