

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.

DEC 13 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 701 9

39116
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. 1003/

(b) Township Primary Registration District No. 10103

(c) City ST. LOUIS MO (d) Street No. En route City Hospital #1 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MYRTLE CHAMBERS BLAND.

(a) Residence, No. 307 RUTGER ST. St. 22 (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) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 22 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

54 2 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

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

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) Missouri

13. NAME UNK. CHAMBERS

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

15. MAIDEN NAME UNKNOWN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) John BLAND, 307 RUTGER.

18. BURIAL, CREMATION, OR REMOVAL PLACE ST. MATTHEWS CEM DATE NOV. 1937

19. FUNERAL DIRECTOR (ADDRESS) E. J. Schurz, 3125 Lafayette Ave

20. FILED NOV 1 1937 J. Boedeker Local Registrar.

NO MEDICAL CERTIFICATE OF DEATH
NO PHYSICIAN IN ATTENDANCE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/27/37 19

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 10:05 P.M.

The principal cause of death and related causes of importance were as follows:

Chronic Interstitial Nephritis.

Arteriosclerosis.

Other contributory causes of importance: 1/31

Date of onset

Name of operation..... 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) Joseph M. Lusk, M.D. (Address) Deputy Coroner

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

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

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)