

REC'D MAY 10 1938

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

791

1003

13002

Do not use this space.

3606

## 1. PLACE OF DEATH

(a) County.....

(b) Township.....

(c) City St. Louis, Mo.

(e) Length of residence in city or town where death occurred

Registration District No.....

Primary Registration District No.....

(d) Street No. City Hospital #1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(f) How long in U. S., if of foreign birth? yrs. mos. ds. yrs. mos. ds.

## 2. PRINT FULL NAME

Robert Alcorn *4-2-13*(a) Residence, No. 4527 N. Market St. 11

(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

## 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

6/4/36

## 7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ..... hrs. or ..... min.

22 months / 101013

## 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)

City

## FATHER

13. NAME Homer Alcorn14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

## MOTHER

15. MAIDEN NAME Erma West16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.17. INFORMANT Hosp. info. M. Williams  
(ADDRESS) City Hospital #1

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE Valhalla DATE April 19 193819. FUNERAL DIRECTOR (NAME) Arthur J. Donnelly  
(ADDRESS) 3840 Litchfield Ave20. FILED APR 18 1938J. D. Bredich  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/17/38 19..22. I HEREBY CERTIFY, That I attended deceased from 4/17/38, 19.. to 4/17/38, 19..I last saw him alive on 4/17/38, 19.. Death is said to have occurred on the date stated above, at 1:55 P.M.

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

Date of onset  
Acute lymphatic leukemia 1938  
Strep throat non-disruptive 1938  
Sepsis 1938  
720

Other contributory causes of importance:

Long abscess, no pneumonia 1938  
Non TB, caused by strep sore throat

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? Yes

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) W. B. ... M. D.(Address) 1515 Lafayette

**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.....

Licensed Embalmer No.....

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.**