

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

22021  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Iron Registration District No. 391  
 (b) Township Carcedo Primary Registration District No. 4239 Registered No. 41  
 (c) City Fronton (d) Street No. St. Marys 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME Mario Alexander 425  
 (a) Residence, No. 5869 Julian St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Divorced  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 28, 1908  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
30 2 16  
 OCCUPATION 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 0  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo  
 FATHER 13. NAME L. R. Alexander  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo  
 MOTHER 15. MAIDEN NAME L.R. unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 4<sup>th</sup> 1938  
 22. I HEREBY CERTIFY That I attended deceased from July 3<sup>rd</sup> 1938 to July 4<sup>th</sup> 1938  
 I last saw him alive on July 4<sup>th</sup> 1938 Death is said to have occurred on the date stated above, at 2:20a m.  
 The principal cause of death and related causes of importance were as follows:

Date of onset  
INTESTINAL OBSTRUCTION -  
C. GANGRENE OF SMALL  
INTESTINE - ✓  
 Other contributory causes of importance:

Name of operation NONE Date of  
 What test confirmed diagnosis? NONE 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  
 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) Stops, M. D.  
 (Address) Fronton, Mo  
3523

17. INFORMANT (ADDRESS) Roy Schaper 3312 - 1/2 Rebekah St. L. Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY BEM DATE July 7 1938  
 19. FUNERAL DIRECTOR (ADDRESS) G. J. Donnell 174. Cu 3840 Luedd Red Mt. San Jo  
 20. FILED July 4 1938 R. A. Rasche Local Registrar.

1220

STATEMENT BY LICENSED EMBALMER

I, ALFRED F. BOEDEKER, Licensed Embalmer No. 2663

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 Alfred F. Boedeker  
Licensed Embalmer No. 2663

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

22021  
Do not use this space.

1. PLACE OF DEATH:  
 (a) County Iron Registration District No. 391  
 (b) Township Franklin Primary Registration District No. 4230 Registered No. 41  
 (c) City Frankton (d) Street No. \_\_\_\_\_ 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 Marie Alexander  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED DW  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
30 2 16

OCCUPATION  
 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.  
 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) \_\_\_\_\_

FATHER  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 4 1938

22. I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Intestinal obstruction Date of onset \_\_\_\_\_  
+ Gangrene of small intestine \_\_\_\_\_  
 Other contributory causes of importance: Probably due to adhesions of previous operation.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) George W. Gay, M. D.  
 (Address) Frankton

SUPPLEMENTARY

Local Registrar.

REGISTERED SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE FULFILLED AS PRESCRIBED BY LAW

