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.

REC'D DEC 12 1939

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

791

37230

Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 9557

(c) City St. Louis, Mo. (d) Street No. St. Johns St. John's 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 652 Helina Brinker

(a) Residence, No. 4434 Forest Park, Blvd. St. 19
(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) July 22/1890

7. AGE: YEARS 48 | MONTHS 3 | DAYS 10 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Registered Nurse
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) Unknown Missouri

FATHER
13. NAME Henry Brinker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany

MOTHER
15. MAIDEN NAME Helina Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Illinois

17. INFORMANT (ADDRESS) John Brinker Carrollton, Illinois

18. BURIAL, CREMATION, OR REMOVAL
PLACE Carrollton, Illinois DATE Nov. 5/ 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe, Inc. 4700 Washington, Blvd.

20. FILED NOV 3 1938 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

Attending Physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 2/ 1938

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 12:30 P.M.

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

Chronic Myocarditis
Surgical Shock following removal of tubes & ovaries
(undetermined as to malignancy)

Date of onset

Other contributory causes of importance:

Rt. ovarian cyst

Name of operation ..... Date of 11-1 Yes

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? No
If so, specify .....

(Signed) Joseph M. Quinn M. D.
(Address) Deputy Coroner St. Louis, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address .....

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

If this body is not embalmed, above space should be left blank.