

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 1938

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

37600
Do not use this space.

791
1008

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City St. Louis (d) Street No. City Hospital No. 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

459 Kate Bollinger
(a) Residence, No. 3929 Cottage 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/red 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15th 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 4 2

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) St. Louis 0

FATHER 13. NAME John Harper

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England 4

MOTHER 15. MAIDEN NAME Jenny Alley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland 4

17. INFORMANT (ADDRESS) Hos p. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE St Peter's Cem DATE 11-17-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sullivan
2849 N. Grand

20. FILED NOV 17 1938 J. F. Prebeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/16/38 1938

22. I HEREBY CERTIFY, That I attended deceased from 9/2/38 1938 to 11/16/38 1938

I last saw h. live on 11/16/38 1938 Death is said

to have occurred on the date stated above, at 9:55 p.m.

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

Carcinosis of Lungs
Date of onset

Other contributory causes of importance:

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) M. A. Hall M. D.
(Address) City Hospital No. 1

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.....

Albert Mayfield....., Registered Apprentice No.....
working under my personal supervision.

Signed *Albert Mayfield*
Licensed Embalmer No. *13077*

P. O. Address.....

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

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