

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

37746

Do not use this space.

791

1003

Registered No. 10073

1. PLACE OF DEATH DEC 12 1938

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis (d) Street No. City 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 524 Clarence Anglemyre

(a) Residence, No. 5760 DeGiverville St. 5 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

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

22. I HEREBY CERTIFY, That I attended deceased from 11/10 1938 to 11/21/38 1938
 I last saw h. him die on 11/21/38 1938 Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 15, 1869

to have occurred on the date stated above, at 11.25 a
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 69 7 6

Degenerative heart disease
respiratory pneumonia
Hydrothorax, bilateral.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Chemical salesman
 9. Industry or business in which work was done, as saw mill, bank, etc. salesman in ret
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

Date of onset

Other contributory causes of importance: Q3C

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wabash Indiana

FATHER 13. NAME Sam Anglemyre

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Un known

MOTHER 15. MAIDEN NAME Elizabeth Douglas

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? Ohio

17. INFORMANT (ADDRESS) Hosp. Info I. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park Tues. 11-22-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alexander and Sons 6175 Delmar Blvd.

20. FIL NOV 22 1938 J. Bredeck Local Registrar

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?.....
 If so, specify Dr. Maxwell, M. D.
 (Address) City Hospital No. 1

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.

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.....

J Wm Dentley....., Registered Apprentice No.....
working under any personal supervision.

Signed *J Wm Dentley*
Licensed Embalmer No. *3653*
P. O. Address *St. Louis Mo*

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.