

REC'D FEB 10 1939

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

262

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **Firmin Desloge 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 **331 Thomas A Whitehead**

(a) Residence, No. **Esther, Missouri** St. **Esther, Missouri.**
(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 **male** 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) **Sept. 17, 1887**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
51 3 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Shoe Repair**
9. Industry or business in which work was done, as saw mill, bank, etc. **Self**
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) **Missouri**13. NAME **Samuel Whitehead**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**15. MAIDEN NAME **Sarah Ann Cook**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**17. INFORMANT (ADDRESS) **Mrs. Nettie Birdsall**
900a LaSalle St18. BURIAL, CREMATION, OR REMOVAL PLACE **Boone Terre, Mo.** DATE **1/9/39**19. FUNERAL DIRECTOR (ADDRESS) **A. W. McLaughlin**
2301 Lafayette Avenue20. FILED **JAN 9 1939**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1/7/39**, 19

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw him..... alive on 19..... Death is said to have occurred on the date stated above, at **10:30 A.M.**

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

Renal Arteriosclerosis
Date of onset

Other contributory causes of importance:

Reliac Hypertrophy

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.....

(Signed) **Joseph W. Turner**(Address) **Deputy Coroner**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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, L. R. Cooper, Licensed Embalmer No. 3633

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed L. R. Cooper

Licensed Embalmer No. 3633

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.)