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 FEB 10 1939

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

283
Do not use this space.

1. PLACE OF DEATH
(a) County 2 Registration District No. 791
(b) Township Primary Registration District No. 1003 Registered No. 283
(c) or City St. Louis 1 (d) Street No. 3618 Hydraulic 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 656 Dollie Turner
(a) Residence, No. 3618 Hydraulic St. 16
(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): married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: William F.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct. 21, 1870
7. AGE: YEARS 68 MONTHS 2 DAYS 16 If LESS than 1 day, ...hrs. or ....min.

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. at home
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): Louisiana, Mo.

FATHER
13. NAME: ------Aldridge
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

MOTHER
15. MAIDEN NAME: unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

17. INFORMANT (ADDRESS): Martin J. Turner, 3618 Hydraulic
18. BURIAL, CREMATION, OR REMOVAL PLACE: Herr St Marcus DATE: Jan 9 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): John L. Ziegenhein & Sons, 7027 Gravois Ave
20. FILED: JAN 9 1939 J. F. Budick, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan. 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept, 1937, to Jan 7, 1939
I last saw her alive on Jan 7, 1939 Death is said to have occurred on the date stated above, at 9:50 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Uterus	

Other contributory causes of importance:
Carcinoma metastasis to liver & lungs

Name of operation: D & C Date of: 9-9-37
What test confirmed diagnosis? Biopsy 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, 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) Royal A. Weir M. D.
(Address) 1703 So Grand

(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 Clarence P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 6937a Gravois a

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

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