

REC'D FEB 27 1939

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

3676
Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Mo Registration District No. 757
 (b) Township St. Charles Mo Primary Registration District No. 3036 Registered No. 11
 (c) City St. Charles Mo (d) Street No. 2901 Benton Ave 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 Allie Mae Singleton
 (a) Residence, No. St Charles Mo St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Frank Singleton

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 10 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc. Housewife
 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) Warren County Mo.

FATHER 13. NAME David Sherman
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

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

17. INFORMANT (ADDRESS) Frank Singleton

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cemetery DATE Feb 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. B. Dellmeyer
St Charles Mo

20. FILED 2/1 1939 Clarence H. Neesler
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 29th 1939

22. I HEREBY CERTIFY That I attended deceased from November 26 1938, to January 29 1939
 I last saw h.s.v. alive on January 29 1939. Death is said to have occurred on the date stated above, at 12:45 p.m.
 The principal cause of death and related causes of importance were as follows:

Coronary artery disease
Affected
 Date of onset Jan 27, 1939
 Other contributory causes of importance: Generalized arteriosclerosis 135

Name of operation _____ Date of _____
 What test confirmed diagnosis? Exam 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? No
 If so, specify _____
 (Signed) George E. Tester M. D.
St Charles, Mo (Address)

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.

OCT 10 1945

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.....

Licensed Embalmer No.

P. O. Address

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

3676

Do not use this space.

1. PLACE OF DEATH *St Charles*

(a) County *St Charles* Registration District No. *75-7*
 (b) Township *St Charles* Primary Registration District No. *3836* Registered No.
 (c) City *St Charles* (d) Street No. 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 *Allie May Singleton*

(a) Residence, No.
 (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 *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *SM*
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 20, 1881*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
57 10 9

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.
 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)

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED *788* 19*39* *Clarence B. Keebler* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-29-1939*

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..... m.
 The principal cause of death and related causes of importance were as follows:
 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 *Geo. E. Fester*, M. D.
 (Signed) *St Charles*
 (Address) *mo*

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

