

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.

17 1939 ¹⁹³⁹ MAR 9 1939

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

7731
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Clayton Primary Registration District No. 101 Registered No. 282
 (c) City Clayton (d) Street No. St. Louis County 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 650 Julia Green
 (a) Residence, No. St. Charles & Charbonniere, Florissant, Mo.
 (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 colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 18, 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>74</u>	<u>6</u>	<u>28</u>	

OCCUPATION
 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) Mo. C

FATHER
 13. NAME John Page 9
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? C

MOTHER
 15. MAIDEN NAME Helen Taylor
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT sister, Letitia Phoenix
 (ADDRESS) St. Chas. & Charbonniere, Florissant

18. BURIAL, CREMATION, OR REMOVAL PLACE Blackjack, Mo. DATE 2/18/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. L. Beal
2726 Lucas

20. FILED FEB 17 1939 D. R. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/15/39 19

22. I HEREBY CERTIFY, That I attended deceased from 2/12/39 19 to 2/15/39 19.
 I last saw h. er alive on 2/15/39 19. Death is said to have occurred on the date stated above, at 10:55A.M.
 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia Date of onset 7/6/39

Other contributory causes of importance:
Unrecognized Arteriosclerosis ?

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) James David, M. D.
 (Address) St. Louis County Hospital

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 Birdie Beol Anderson
Licensed Embalmer No. 2929
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.