

APR 12 1939

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

8186  
Do not use this space.

791  
1003

Registered No. 1951

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City..... **St. Louis** (d) Street No..... **Homer Phillips 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 **9** yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **530 Laura Young**

(a) Residence, No. **1633a Carr** St. **25**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  
**Widowed**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 26**, 19**39**

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

22. I HEREBY CERTIFY, That I attended deceased from **Feb. 6**, 19**39** to **Feb. 26**, 19**39**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 16, 1886**

I last saw him **or** alive on **Feb. 26**, 19**39** Death is said to have occurred on the date stated above, at **3:50p.m.**

7. AGE. YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**52** **8** **10**

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

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

**Tubo-ovarian abscess non mal-ignant cause unknown** Date of onset **2/6/39**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

Other contributory causes of importance:  
**Cystitis non catarrhal non tubercular non gonorrhoeal**

FATHER 13. NAME **Frank Bennie**

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

MOTHER 15. MAIDEN NAME **Eva Mayo**

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

17. INFORMANT (ADDRESS) **Evelyn Hilliard**  
**2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Pine Bluff Ark** DATE **March 1, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **H. E. S. Garner**  
**2829 Washington**

20. FILED **MAR 1 1939** **J. B. Buehler** Local Registrar

Name of operation..... Date of.....  
What test confirmed diagnosis? **clinical** 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) **Hubert C. Curtis**, M. D.  
(Address) **2601 N Whittier**

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

Book 0 233

DATE OF DEATH

PLACE HERE  
THE NAME OF THE  
DECEASED

ON

AT

IN

STATE OF

TO

BY

REGISTERED

APPRENTICE

IN PRESENCE OF

**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

*Arthur L. Heilbard*

Licensed Embalmer No. *3388*

P. O. Address *3028 Decker*

**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.