

I X12004

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.

4369 Delman
1939 APR 12 1939-2887

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

8456
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Mo. Registration District No. 791

(b) Township 1 Primary Registration District No. 1003 Registered No. 2221

(c) City St. Louis Mo. (d) Street No. 4630a McMillan Av. St. Mo.
(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 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nettie Bidans

(a) Residence, No. 4630a McMillan Av. St. 12 (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) DIVORCED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 17-1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	<u>91</u>	<u>11</u>	<u>18</u>	

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) Unknown

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME "

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

17. INFORMANT (ADDRESS) Mrs. G. W. Payne
5910 Washington Rd.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Matthews DATE 3/9 1939

19. FUNERAL DIRECTOR (ADDRESS) Chas. R. Bull
4452 Washington Rd.

20. FILED 1939 J. F. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/7 - 1939

22. I HEREBY CERTIFY, That I attended deceased from March 1, 1939, to March 7th, 1939
I last saw h. or alive on 3/7, 1939. Death is said to have occurred on the date stated above, at 6 a. m.
The principal cause of death and related causes of importance were as follows:

Cataract (Ch) Gastric ulcer of stomach (Ch)

Other contributory causes of importance: Old age

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? No.
If so, specify _____
(Signed) J. C. Thurman M. D.
(Address) 4369 Delman Blvd.

MAK 8 1939

STATEMENT BY LICENSED EMBALMER

I, John Ketter, Licensed Embalmer No. 3880

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

..... L. E.

No. or by, Registered Apprentice No. 3880
working under my personal supervision.

Signed

John Ketter

Licensed Embalmer No.

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.)