

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1008

13190
Do not use this space.

3532

REC'D MAY 10 1939

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No.....
 or City St. Louis (c) Street No. St. Anthony's 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 Catherine Mawdsley

(a) Residence, No. 2934 Allen St. 17
 (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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF (late) Geo. R. Mawdsley
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-6-1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 70 0 7
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 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) St. Louis, Mo.

FATHER 13. NAME Joseph Marks

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) Clarence Mawdsley
2934 Allen

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE 4-17 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lynden Lund Co.
6322 S. Grand

20. FILED APR 17 1939 J. J. [Signature]
Loch Robinson

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-13 19 39

22. I HEREBY CERTIFY, That I attended deceased from 4-4 1939, to 4-13 1939

I last saw h. er alive on 4-13 1939 Death is said to have occurred on the date stated above, at 4:05 p.m.
 The principal cause of death and related causes of importance were as follows:

Broncho-pneumonia Date of onset 3 wks
[Signature]

Other contributory causes of importance: Chronic myocarditis yrs

Name of operation..... Date of.....
 What test confirmed diagnosis? clinical 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) Walter M. Jones, M. D.
 (Address) 3400 [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.

Dr. W. Jones
3400

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.....

Frank Ludwig....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Frank Ludwig*.....

Licensed Embalmer No. *2504*

P. O. Address *6222 So Grand*

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.