

REC'D JUN 12 1939

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

16580  
Do not use this space.

## 1. PLACE OF DEATH

(a) County.....<sup>2</sup> Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City St Louis mo (d) Street No. 303 Cedar St. 4114  
(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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

(a) Residence, No. 303 Cedar St. 22 (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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>mar 1, 1939</u>			
7. AGE	YEARS	MONTHS	DAYS
<u>Steel Born</u>			
If LESS than 1 day, ..... hrs. or ..... min.			
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		
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>303 Cedar Apt 7</u> <u>St Louis mo</u>		
	13. NAME <u>Charles Parles</u>		
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill</u>		
	15. MAIDEN NAME <u>Ann Pirtle</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Quincy Ill</u>		
17. INFORMANT (ADDRESS) <u>Charles Parles</u> <u>303 Cedar</u>			
18. BURIAL, CREMATION, OR REMOVAL <input checked="" type="checkbox"/> <u>CITY CEMETERY</u> DATE <u>4-21</u> 19 <u>39</u>			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>(City) Ira Hamilton</u> <u>City Health Dept</u>			
20. FILED <u>MAY 4 1939</u> <u>J. B. Budick</u> Local Registrar			

## MEDICAL CERTIFICATE OF DEATH.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) mar 1 1939.

22. I HEREBY CERTIFY, That I attended deceased from mar 1 1939, to mar 1 1939.  
I last saw him alive Steel Born 1939. Death is said to have occurred on the date stated above, at 2:40 m. Steel Born  
The principal cause of death and related causes of importance were as follows:  
Card Arrod Weak.  
Skin emaciated  
Duodenal?

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: \_\_\_\_\_  
(Signed) J. R. Walling, M. D.  
(Address) 740 54

**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.**