

REC'D JUN 17 1939

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

701
1008

17160

Do not use this space.

4694

1. PLACE OF DEATH

(a) County..... 1 Registration District No.....
(b) Township..... St. Louis Primary Registration District No.....
(c) City..... (d) Street No. City Hospital No. 1 Registered No.....
(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.

E. 1803

2. PRINT FULL NAME

(a) Residence, No. 2321 Howard St. 20 (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 male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

Isabelle

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3, 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
58 11 14

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) Illinois

13. NAME Joseph Burch

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

15. MAIDEN NAME Catherine Haynes

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Genevieve DATE 5-25-39

19. FUNERAL DIRECTOR (NAME) A. H. Apple

(ADDRESS) 4700 Washington

20. FILED MAY 24 1939

J. B. Burch

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/17/39 19

22. I HEREBY CERTIFY, That I attended deceased from 5/8/39 19, 5/17/39 19

I last saw him alive on 5/17/39 19. Death is said to have occurred on the date stated above, at 5:30 a.m.

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

Pulmonary Tbc

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. F. Priddy, M. D.

(Address) City Hospital No. 1

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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 *Christ. W. Kappre*

Licensed Embalmer No. *1861*

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.