DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20745

REC'D JUL 12 1939

Registration District No. 791

Primary Registration District No.

Registrar's No. 5589

1. PLACE OF DEATH: 1003 ~~2602 rear Franklin Ave.~~

(a) County

(b) City or town ST LOUIS

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2604 FRANKLIN Av. Rear

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 1 21

(If outside city or town limits, write "RURAL")

(d) Street No. 2604 rear Franklin, Ave.

(If rural, give location)

(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME Girldine Anderson White

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Female

5. Color or race Col.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife August White

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years About 50 Months Days If less than one day hr. min.

9. Birthplace Fulton, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Oldon ?

13. Birthplace Fulton (City, town, or county) Missouri (State or foreign country)

MOTHER 14. Maiden name Eliza Williams

15. Birthplace Fulton (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature August White

(b) Address 2604 rear Franklin, Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-39 (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson Cemetery

18. (a) Signature of funeral director A. L. Garner

(b) Address 2829 N Washington Ave

19. (a) JUN 24 1939 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19th year 1939 hour 12 05 minute A. M.

21. I hereby certify that I attended the deceased from April 26 1939 to June 19 1939 that I last saw her alive on June 19 1939 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(a) Congestive Heart Failure	2 wks
Due to Mitral Insufficiency	Chronic
Due to Rheumatic Fever	
Other conditions (Include pregnancy within 3 months of death) Hypertension, Pulmonary Edema, Nephritis	Chronic

Major findings:
Of operations
Of autopsy 131

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature S. E. Mason (M. D. or other)

Address 869 N. Jefferson Date signed 6/25/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 (1 X19511)

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. Heilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson

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.