

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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

21132
Do not use this space.

REC'D JUL 10 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township 13th S. W. Primary Registration District No. 1002 Registered No. 2460
 (c) City St. Louis, Mo. (d) Street No. General Hospital 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 210 Chester McAfee (Chester McAfee) St. (If nonresident, give city or town and State)
2525 Summit (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 24 1890
 7. AGE YEARS 49 MONTHS 4 DAYS 11 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. M.P.A.
 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) MO
 13. NAME Milton McAfee
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
 15. MAIDEN NAME Ann Bocking
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT (ADDRESS) Records Clerk 15 E. Sun West
 18. BURIAL, CREMATION, OR REMOVAL Records Dept DATE 6-13-39
 19. FUNERAL DIRECTOR (ADDRESS) Wm A. Johnson
 20. FILED June 12, 1939 M.M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-4-39
 22. I HEREBY CERTIFY, That I attended deceased from 5-25-39, 19____ to 6-4-39, 19____
 I last saw him alive on 6-4-39, 19____ Death is said to have occurred on the date stated above, at 5:15 p.m.
 The principal cause of death and related causes of importance were as follows:

Post operative Cancer Date of onset _____
remnant of neck
53

Other contributory causes of importance:
Pulmonary congestion

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes
 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) P. A. De Maria M.D.
Asst. H.C. Sun West

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.