

REC'D AUG 11 1939

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

24102
Do not use this space.
6375

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City or **St. Louis, Missouri** (d) Street No. **City Sanitarium** Registered No. **6375**
(e) Length of residence in city or town where death occurred **55** (If death occurred in Hospital or Institution, write its name instead of street and number) St.
7 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **708 Dover Place** St. **1**
(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 **Single**
(If divorced, write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **6-2-1884**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 1 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housework**
9. Industry or business in which work was done, as saw mill, bank, etc. **Housework**
10. Date deceased last worked at this occupation (month and year) **1930** 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri** **0**

FATHER 13. NAME **John Conrad** **0**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Missouri** **7**

MOTHER 15. MAIDEN NAME **Angelique L'Ange**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **France**

17. INFORMANT **A.K. Busch, M.D.**
(ADDRESS) **5400 Arsenal St**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Mt. Olive** DATE **7-20 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Southern Ind. Co. 6322 S. Grand**

20. FILED **JUL 19 1939** **J.P. Braddock** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-17-39** 19

22. I HEREBY CERTIFY, That I attended deceased from **4-3-1939**, 19, to **7-17-39**, 19.

I last saw her alive on **7-17-39**, 19. Death is said to have occurred on the date stated above, at **10:45 a.m.**
The principal cause of death and related causes of importance were as follows:

Carbuncle 7-1-39
Septicemia 7-5-39

Other contributory causes of importance:
Lung Abscesses 7-10-39
Kidney Abscesses 7-10-39
following carbuncle

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) **A.K. Busch**, M. D.
(Address) **City Sanitarium**

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.

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.....

Virgil L. Berryman

Licensed Embalmer No. *4018*

P. O. Address.....

St. Louis Mo.

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.