

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.

AUG 11 1939

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

24396
Do not use this space.
6669

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003** Registered No.
(c) City St. Louis, Mo. (d) Street No. St. Louis Children's Hospital St.
(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 Ruth Judith Oliver 416

(a) Residence, No. Percy, Illinois St. **NR** Percy Illinois.
(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 F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 18, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 11
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. Child
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) Percy, Illinois

FATHER 13. NAME Harold

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

MOTHER 15. MAIDEN NAME Glady's Buescher

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

17. INFORMANT Harold Oliver
(ADDRESS) Percy, Illinois

18. BURIAL, CREMATION, OR REMOVAL PLACE Chester Illinois DATE 8/1/39

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe
(ADDRESS) 4700 Washington Blvd.

20. FILED JUL 31 1939

J. B. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 29, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 29, 1939, to July 29, 1939

I last saw h.c.v. alive on July 29, 1939. Death is said to have occurred on the date stated above, at 11:45 a.m.

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

Lobar pneumonia bilateral
Congenital syphilis
Acute leukemia
Malaria
Septicemia

Date of onset 7-28-39

Other contributory causes of importance: Arteriosclerosis

Name of operation None Date of

What test confirmed diagnosis? His serum 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

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 None

(Signed) [Signature], M. D.

(Address) 500 So. Kingshighway

No 6669
6669
Embalmed

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.