

REGD SEP 14 1939 **791**

Registration District No. 1003

Primary Registration District No. _____

Registrar's No. 6919

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 Days
(Specify whether _____)
 In this community 40 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3754 Westminster Pl
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8,
 year 1939 hour 11:30 minute A. M.
 21. I hereby certify that I attended the deceased from August
2, 1939, to August 8, 1939;
 that I last saw her alive on August 8, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Cerebral Haemorrhage</u>	<u>3 wks</u>
<u>Diabetes Mellitus</u>	<u>-</u>
<u>Myofasciatic Pneumonia</u>	<u>1 Day</u>

Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings:
 Of operations _____
 Of autopsy _____

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 Samuel Liebman (M. D. or other) MD
 Address City Hospital Date signed 8/8/39

3. (a) PRINT FULL NAME Mary Boyer
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Jule Boyer
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 16, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>8</u>	<u>23</u>	_____ hr. _____ min.

9. Birthplace Adams County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER {
 12. Name William Evans
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Mae Ellsworth
 (b) Address 801 Military Rd.

17. (a) Burial (b) Date thereof 8/11/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O. S. S. Peters Paul

18. (a) Signature of funeral director Wacker-Helderte
 (b) Address 2331 S. Broadway

19. (a) AUG 9 1939 (b) J. F. Brudick
(Date received local registrar's certificate) (Registrar's signature)

WHILE FERRIS 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.

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..... *Frank J. Wylanc Jr.*.....

Licensed Embalmer No..... *2645*.....

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.