

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

REC'D SEP 14 1939

27540  
Do not use this space.  
7040

1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003**  
 (c) City **St Louis Mo** (d) Street No. **St Lukes Hospital** Registered No. **7040**  
 (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 **Alma Rose Vedder (Vedder)**

(a) Residence, No. **Commerce, Missouri** St. **NR** **Commerce, Missouri**  
 (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 (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **8-16-1920**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**18 11 16**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Student**  
 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) **Commerce, Missouri**

FATHER 13. NAME **Otto Vedder**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Scott County, Mo.**

MOTHER 15. MAIDEN NAME **Elizabeth LeDune**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Scott County, Mo.**

17. INFORMANT (ADDRESS) **Otto Vedder Commerce Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **Commerce Mo 8-12-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Hannan Funeral Home Cape Girardeau**

20. FILED **AUG 14 1939**

*J. B. ...*  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Aug. 12th 1939**

22. I HEREBY CERTIFY, That I attended deceased from **August 7 1939, to August 12 1939**

I last saw him alive on **August 12 1939**. Death is said to have occurred on the date stated above, at **2:43 p.m.**  
 The principal cause of death and related causes of importance were as follows:

**Cerebellar brain tumor malignant**  
**53**

Other contributory causes of importance:

Name of operation **Cerebellar craniotomy** Date of **Aug 11 1939**  
 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  
 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) **James B. Jones**, M. D.  
 (Address) **St. Louis Hospital, St. Louis, Mo.**

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.

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**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 Howard F. Rowland

Licensed Embalmer No. 3114

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.**