

WRITE PLAINLY—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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 14 1939

791
1008

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27678

Registrar's No. 7178

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Stillborn Ewalt 430

3. (b) If veteran, name war Nil 3. (c) Social Security No. Nil

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Stillborn

6. (b) Name of husband or wife Nil 6. (c) Age of husband or wife if alive Nil years

7. Birth date of deceased Aug. 17 1939
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	0	0 hr. 0 min.

9. Birthplace St. Louis Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

MOTHER { 12. Name Eveett Ewalt

13. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name Ruth Cornwell

15. Birthplace St. Louis, M Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Eveett E. Ewalt

(b) Address 3934 W. Foley Mo.

17. (a) Burial (b) Date thereof Aug 18 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Quadruppa & Sons

(b) Address 3934 W. Foley Mo.

19. (a) AUG 18 1939 (b) J. B. ...

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17
 year 1939 hour 12:15 PM minute _____ M.

21. I hereby certify that I attended the deceased from Aug 17
 1939, to Aug 17 1939;

that I last saw h _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Stillborn Cord around neck for time

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature J. B. ... (M. D. or other) _____

Address 602 N. Grand Date signed 8-17-39

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

No of Embalmed....., 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.