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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30574

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 7637

1. PLACE OF DEATH:

(a) County 2

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3709a So. Kingshighway Blvd.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 3709a So. Kingshighway Blvd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gladys Babb 100

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Robert Babb

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased December (Month) 4th (Day) 1900 (Year)

8. AGE: Years 38 Months 8 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation Housewife 1

11. Industry or business

FATHER
12. Name Arnold 1
13. Birthplace (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name Ellen Curry
15. Birthplace (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant's own signature Robert Babb
(b) Address 3709a So. Kingshighway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-39 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 So. Kingshighway

19. (a) (Date received local registrar) SEP 4 1939 (b) J. F. Bridgeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1st year 1939 hour 2:10 minute P.M. M.

21. I hereby certify that I attended the deceased from May 10, 1931, to June 11, 1939, that I last saw her alive on 9-1, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of uterus, rectum metastasis

Due to Gener carcinoma

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of uterus
Of autopsy no

Duration

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) None

(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 John S Young (M.D. or other) M.D.

Address 930 Lindell Blvd Date signed 9-2-39

(Licensed Embalmer's Statement on Reverse Side)

Dr. Young
Parklane Hospital Sat. noon

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 Edwin D M Vermott

Licensed Embalmer No. 302 K

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.