

WRITE IN INK—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
DEC 13 1939 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38080
Registrar's No. 9919

Registration District No. 1000 Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis, 1
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: City Infirmary Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution December 24, 1939
8yrs. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis,
(c) City or town St. Louis, 13
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Minnie Dieves. 120
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 8, 1851.
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July 11 day 8, 14
Year 1939 hour 1:00 minute P. M.
21. I hereby certify that I attended the deceased from December 24, 1936 to November 14, 1939
that I last saw her alive on November 14, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
88 4 6 hr. min.

Immediate cause of death
Degenerative Heart Disease
Due to arteriosclerosis
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy none

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation No Occupation. 9
11. Industry or business X 9
12. Name William Dieves 9
13. Birthplace Unknown. 9
(City, town, or county) (State or foreign country)
14. Maiden name Charlotte Trout. 9
(City, town, or county) (State or foreign country)
15. Birthplace Unknown. 9
(City, town, or county) (State or foreign country)

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 _____

MOTHER FATHER
16. (a) Informant's own signature O. Molony
(b) Address 5800 Arsenal St.
17. (a) Burial (b) Date thereof NOV 21 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director J. Ryan
(b) Address City Infirmary
19. (a) NOV 21 1939 (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature Geo. S. Bogalis, M.D. (M. D. or other)
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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.