

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38310
Registrar's No. 10149

50 DEC 12 1939 791
Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: 101083
(a) County St. Louis 2
(b) City or town St. Louis Mo.
(c) 5137 Palm St.
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 1
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 5137 Palm
(If rural, give location)
(e) If foreign born, how long in U. S. A. 50- years.

3. (a) PRINT FULL NAME Yetta Oksner 256
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov 28 day _____
year 1939 hour _____ minute 12:30 a.m.

4. Sex Female 5. Color white 6. (a) Single, widowed, married, divorced widowed
7. Birth date of deceased not known
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 1939 to Date, 1939
that I last saw her alive on Nov 27, 1939; and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hemorrhage Duration _____

8. AGE: Years about 74 Months _____ Days _____ If less than one day _____
hr. _____ min. _____

Due to Hypertension OK
Due to _____

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

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

10. Usual occupation House wife 7
11. Industry or business not known
12. Name Poland 7
13. Birthplace not known 7
(City, town, or county) (State or foreign country)
14. Maiden name not known 7
15. Birthplace Poland 7
(City, town, or county) (State or foreign country)

Major findings: none
Of operations _____
Of autopsy none

16. (a) Informant's own signature SI Oksner
(b) Address 5137 Palm
17. (a) Burial (b) Date thereof Nov. 29-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director Herman Ruds Koff
(b) Address 3216 Bertha
Nov 30 1939
19. (a) _____ (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury none
23. Signature John C. Brown MD (M. D. or other)
Address 4578 Washington Ave Date signed 11-28-39

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.

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Chas W. Cooper

Licensed Embalmer No. 3830

P. O. Address 5216 Delmar

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.