

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. \_\_\_\_\_  
Registrar's No. 4963

JUL 17 1940 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Gideon  
(If outside city or town limits, write "RURAL") NR

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

3. (a) PRINT FULL NAME Velma Ada Fewell 1407

3. (b) If veteran, name war No. \_\_\_\_\_

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 Mack 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Aug. 30 1890  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5  
year 1940 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from 6-3-  
1940, to 6-5-, 1940;

that I last saw her alive on 6-5-, 1940;  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>9</u>	<u>5</u>	hr. _____ min. _____

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to 1) Uremia - toxic nephritis caused by chronic glomerulonephritis

Due to 2) Corthia - sclerotic heart disease & decompensation

Other conditions Acute arthritis  
(Include pregnancy within 3 months of death)

Major findings: Obesity

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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8. Birthplace Wayne Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm. Hedrick

13. Birthplace N. Carolina  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Birch

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

16. (a) Informant's own signature Emmanuel Hedrick

(b) Address 3884a Wyoming

17. (a) Removal (b) Date thereof 6-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarkton, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUN 6 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Signature)

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 Ale Mueller (M. D. or other) \_\_\_\_\_

Address BARNES HOSPITAL Date signed 6/5/40

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.

FORM 5-17-39  
REV. 5-17-39  
U. S. GOVERNMENT PRINTING OFFICE

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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.....

*Albert G. Hoppa*

Licensed Embalmer No.....

*2571*

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.**