

AUG 1940  
 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.

Registration District No. 284 Primary Registration District No. 117

1. PLACE OF DEATH: Webster Groves Mo.  
 (a) County \_\_\_\_\_  
 (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: 225 Lythia Ave  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community About 3 years  
 years, months or days (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County St. Louis  
 (c) City or town Webster Groves Mo.  
 (d) Street No. 225 Lythia Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Renfro  
 3. (b) If veteran, name war No.  
 3. (c) Social Security No. No.

4. Sex Female 5. Color or race Colored  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Not Known  
 6. (c) Age of husband or wife if alive Not Known  
 7. Birth date of deceased Not Known  
 (Month) (Day) (Year)

8. AGE: Years About 74 Months \_\_\_\_\_ Days \_\_\_\_\_  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jacksonville Mo. (State or foreign country) Mo.

10. Usual occupation Housework

11. Industry or business Nelson Owens

12. Name Mo.

13. Birthplace \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name Nancy Parkins

15. Birthplace Mo. (State or foreign country) \_\_\_\_\_

16. (a) Informant's own signature Lee Etts Summytt

(b) Address 225 Lythia Ave.

17. (a) Burial (b) Date thereof AUG 12, 1940

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director A. T. Beal Und Co.

(b) Address 2726 Lucas Ave.

19. (a) AUG 12 1940 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 8 day 8  
 year 1940 hour 6:10 minutes AM  
 21. I hereby certify that I attended the deceased from 8/4  
 \_\_\_\_\_, 1940 to 8/8, 1940  
 that I last saw her alive on \_\_\_\_\_, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Heat Exhaustion with senescence  
 Due to Arteriosclerosis?  
 Due to Small Arteriosclerosis?  
 Other conditions As above stated  
 (Include pregnancy within 3 months of death)

Duration 5 days  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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?  
707 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 28. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address 809 East Jefferson Date signed 8/12/40

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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..... *Birdie Beal Andersen*

Licensed Embalmer No. *2929*

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26259  
Registrar's No. 1574

Registration District No. .... Primary Registration District No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Mary Renfro

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8-12-40 (b) \_\_\_\_\_ (Registrar's signature)

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH. Month Aug, Day 8, Year 1940  
hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1940 to \_\_\_\_\_ 1940  
that I last saw her alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Heart affection  
not a heart stroke  
Due to Arteriosclerosis  
senile dementia  
Other conditions Senility  
(Include pregnancy within 3 months of death) 99

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) \_\_\_\_\_ (Means of injury)

23. Signature D. Walker (M. D. or other) \_\_\_\_\_  
Address 809 1/2 Jefferson Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

