

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27032

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6928**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **24 hrs.**
(Specify whether _____)
In this community **life**
years, months or days

3. (a) PRINT FULL NAME **May Barslow** **624**

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 **widow**

6. (b) Name of husband or wife **Arhtur** 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased **Nov. 1 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 9 21 13 hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

12. Name **Brohammer**

13. Birthplace **not known** 9
(City, town, or county) (State or foreign country)

14. Maiden name **not known**

15. Birthplace **not known** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **John Burrell**
(b) Address **3961 Federer Pl.**

17. (a) **Burial** (b) Date thereof **Aug. 17, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **John R. Ziegenhain**

(b) Address **7027 Gravois Ave.**

19. (a) **AUG 18 1940** (b) **J. J. Predeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** 1
(If outside city or town limits, write "RURAL")
(d) Street No. **3961 Federer Pl.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **14**
year **1940** hour **2** minute **30** P.

21. I hereby certify that I attended the deceased from **June 17**
19**40** to **Aug 14** 19**40**
that I last saw her alive on **Aug 14** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **acute Myocardial**
Caused by chr Myocarditis *Duration 17 Months*

Due to **Coronary Occlusion** ??

Due to _____

Other conditions **930**
(Include pregnancy within 3 months of death)

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) (e) Means of injury _____

23. Signature **W. J. Demko, M. D.** (M. D. or other) _____

Address **3450 Gravois Ave.** Date signed **8/18/40**

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

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

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

B. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 6937 - Gravois

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.