

U. S. No. 2
Form-1-4-41
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36007**

FILED OCT 28 1941

Registration District No. **101**

Primary Registration District No. **101**

Registrar's No. **2050**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days
(Specify whether years, months or days)

In this community 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 7454 Flora Ave.
(If rural, give location)

(e) Citizen of foreign country? No / (Yes or No)

If yes, name country _____

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3. (a) PRINT FULL NAME Leslie Pirtle

3. (b) If veteran, name war ?

3. (c) Social Security No. ?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6 year 1941 hour 9 minute 07 A. M.

21. I hereby certify that I attended the deceased from 9-16-41 to 10-6-41, 1941; that I last saw her alive on 10-6-41 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race White

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

6. (b) Name of husband or wife Hubert Pirtle

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

7. Birth date of deceased Sept. 30 1897
(Month) (Day) (Year)

Immediate cause of death: Deep fat embolism

Due to ischemic pneumonia

Due to chronic glomerulonephritis & malignant hypertension

Other conditions: 13/1
(Include pregnancy within 3 months of death)

Duration

2 hrs.

2 wks.

3 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

44 0 6 hr. _____ min.

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

10. Usual occupation unemployed

11. Industry or business Waitress

MOTHER FATHER

12. Name unknown unknown

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

14. Maiden name unknown unknown

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

16. (a) Informant Ida Schmidt

(b) Address 7454 Flora

17. (a) _____ (b) Date thereof Oct. 8 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Alto Pass Ill

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Ave. St. Louis, Mo.

19. (a) OCT 7 - 1941 (b) _____
(Date received local registrar) (Registrar's signature)

Major findings: chronic glomerulonephritis

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 Jay B. Smith (M. D. or other) M.D.

Address 7456 Manchester Ave. St. Louis, Mo. 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..... *E. H. Burgess*.....
Licensed Embalmer No..... *4029*.....
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, fact should be so stated above.