WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County St. Louis

Township Central

or

Village

or

City Wellston (NO. 6743 Robbins St. Ave Ward)

Registration District No. 749 File No. 2777

Primary Registration District No. 4472 Registered No. 2

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mattie Houston Currie

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word) Widowed

DATE OF BIRTH _____ (Month) _____ (Day) 1 (Year)

AGE 47 yrs. 7 mos. 25 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Mich

PARENTS

NAME OF FATHER Don't Know

BIRTHPLACE OF FATHER (City or town, State or foreign country) Do

MAIDEN NAME OF MOTHER Do

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Do.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josephine Beck (Daughter)

(ADDRESS) 6743 Robbins Ave

Filed Feby 3 1910 Rella Brace M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

DATE OF DEATH Feby (Month) 1 (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 13, 1909, to Feby 1, 1910, that I last saw her alive on Jany 31, 1910, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

11B
132A Nephritis

(Duration) ___ yrs. 1 mos. ___ ds.

Contributory (SECONDARY) Influenza

(Duration) ___ yrs. 1 mos. ___ ds.

(Signed) J. D. Thurman M. D.

Feby 3 1910 (Address) 6758 Page Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL St. Peters Cem

DATE OF BURIAL Feby 3 1910

UNDERTAKER Geo. L. Pletsch

ADDRESS 5984 Easton Ave

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry; business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191....,

that I last saw h.....alive on ....., 191....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS