

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 _____

Township _____

Village _____

City St. Louis

Registration District No. 791

File No. 37635

Primary Registration District No. 1003

Registered No. 10016

(NO. 2378 Beacon St. Ward)

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

FULL NAME Esther Farmer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH Nov 10, 1913
(Month) (Day) (Year)

DATE OF BIRTH Dec 16th, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 9, 1913, to Nov 10, 1913, that I last saw her alive on Nov 9, 1913, and that death occurred, on the date stated above, at 5 A.m. The CAUSE OF DEATH' was as follows:
Typhoid fever

AGE 2 yrs. 10 mos. 20 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) St. Louis

NAME OF FATHER Joseph Farmer

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

MAIDEN NAME OF MOTHER Bell Kirkpatrick

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Farmer
(ADDRESS) 2378 Beacon Ave

Filed NOV 11 1913 Max C Starkloff REGISTRAR

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. C. Emerson M. D. Nov 10 1913 (Address) 3870 Chestnut

*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 Catharina Cemetery DATE OF BURIAL Nov 11 1913
UNDERTAKER L. J. ... ADDRESS 447 38th W. 20th St.

