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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 28381

or

Village ..... Primary Registration District No. 1003 Registered No. 8200

or

City St Louis (NO. St Marys Infirmary 9 Ward)

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

2 FULL NAME Josie Bardoun

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Divorced

6 DATE OF BIRTH April (Month) 19 (Day), 1877 (Year)

7 AGE 41 yrs. 4 mos. 7 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work Tobacco Worker
(b) General nature of industry business, or establishment in which employed (or employer) Tobacco Factory

9 BIRTHPLACE (City or town, State or foreign country) Bohemia

PARENTS

10 NAME OF FATHER William Bardoun

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

12 MAIDEN NAME OF MOTHER Unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. C. Moydell

(Address) 1926 Allen ave

15 Filed AUG 29 1918, 191 Mae C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 26 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from August 17th, 191..., to August 26th, 1918, that I last saw her alive on August 26th, 1918, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carbuncle (of the chin)

151A

36 YD

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Septicemia

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) Lawrence Thumm M. D.

Aug. 28th, 1918 (Address) 1808 Victor St.

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence 1208 Allen ave

19 PLACE OF BURIAL OR REMOVAL S. Peter & Paul

DATE OF BURIAL Aug 29, 1918

20 UNDERTAKER Wm C Moydell

ADDRESS 1926 Allen ave

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

1 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.]

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH.

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

17 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.

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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