MARGIN RESERVED FOR BINDING

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. 30684

or

Village ..... Primary Registration District No. 1002 Registered No. 8585

or

City S Louis (NO. City Hospital 8 Ward)

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

2 FULL NAME 6688 Petra Morales

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7 AGE: 25 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

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

(b) General nature of industry business, or establishment in which employed (or employer): 131

9 BIRTHPLACE (City or town, State or foreign country): Mexico 131

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE: Hospital Information

(Informant) E Korban

(Address) City Hospital

15 Filed 13 ..., 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH 4

16 DATE OF DEATH: Sept (Month) 3 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 29, 1918, to Sept 3, 1918, that I last saw him alive on Sept 2, 1918, and that death occurred, on the date stated above, at 4:55 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction following Salpingitis (gonorrheal?) 117

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

CONTRIBUTORY (Secondary) General Peritonitis

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

(Signed) Carl C Hein M. D.

Sept 3, 1918 (Address) City Hospital

*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. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence Webster Groves

19 PLACE OF BURIAL OR REMOVAL: POTTERS FIELD

DATE OF BURIAL ....., 191....

20 UNDERTAKER: G. L. Edwards

ADDRESS: 1426 Carroll St

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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

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.

Morally

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

MARGIN RESERVED FOR BINDING

V. S. No. 2. A