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

Registration District No. 781 File No. 30809

Primary Registration District No. 1008 Registered No. 8720

1 PLACE OF DEATH

County

Township or Village or City St. Louis Mo. (No. Bethesda Home St. 28 Ward)

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

2 FULL NAME Minnie A. Leathcart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct (Month) 1st (Day) 1873 (Year)

7 AGE: 44 yrs. 11 mos. 15 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry business, or establishment in which employed (or employer): Bethesda

9 BIRTHPLACE (City or town, State or foreign country): Spartan Ill.

PARENTS

10 NAME OF FATHER: H. J. S. Leathcart

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

12 MAIDEN NAME OF MOTHER: Elizabeth Wright

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bertha A. Leathcart
(Address) 1405 Missouri Ave.

15 Filed SEP 18 1918, 191 Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from Sept. 1, 1918, to Sept. 16, 1918, that I last saw her alive on Sept. 16, 1918, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer Stomach & Liver

40 (Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Saunders M. D.
Sept 17, 1918 (Address) 1541 S. Grand

*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. 28 ds. In the State 20 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence 13 Westmorland Pl.

19 PLACE OF BURIAL OR REMOVAL: Mausoleum Ill. DATE OF BURIAL: Sept 20th, 1918

20 UNDERTAKER: M. H. Alexander ADDRESS: 2833 Olive

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) ....., 1..... (Day) (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

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

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.