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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 31010

or

Village ..... Primary Registration District No. 1003 Registered No. 8959

or

City St Louis (NO. St. Johns Hosp. St.; 25 Ward)

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

2 FULL NAME Louella Horn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

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

6 DATE OF BIRTH Jan (Month) 27 (Day), 1875 (Year)

7 AGE 43 yrs. 8 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) .....

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

PARENTS

10 NAME OF FATHER John C. Brownlee

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

12 MAIDEN NAME OF MOTHER Mary Ann Roberts

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Eva Evans

(Address) Davenport, Iowa

15 Filed SEP 27 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from Sept 2, 1918, to Sept 26, 1918, that I last saw her alive on Sept 26, 1918, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

129 Pneumonia Bronchial

107A

91

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) General peritonitis cause unknown

..... (Duration) ..... yrs. ..... mos. 27 ds.

(Signed) Rocky A Yorell M. D.

Sept 20, 1918 (Address) St Johns Hosp

*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. 12 ds. In the State 9 yrs. 2 mos. ..... ds.

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

Former or usual residence Marquette Hotel

19 PLACE OF BURIAL OR REMOVAL Davenport, Iowa DATE OF BURIAL Sept 28, 1918

20 UNDERTAKER Mullen Hud Co ADDRESS 4069 St Louis Ave.

MISSOURI STATE BOARD OF HEALTH
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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

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