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

31036

**1 PLACE OF DEATH**

County .....

Township ..... or Village ..... or City St Louis (NO. City Hospital St. 7 Ward)

Registration District No. 791 File No. .....

Primary Registration District No. 1003 Registered No. 8983

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

**2 FULL NAME** Lillie Cassery

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: female

4 COLOR OR RACE: white

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

6 DATE OF BIRTH: Feb 28 (Month) (Day) 1871 (Year)

7 AGE: 47 yrs. 6 mos. 29 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Vienna Ills

PARENTS

10 NAME OF FATHER: William Thomas

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

12 MAIDEN NAME OF MOTHER: Don't know Boren

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etta Stevens
(Address) 1205a 8th N

15 Filed SEP 28 1918, 191 Maude Starkloff Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: Sept 24 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from August 1th, 1918, to September 26th 1918, that I last saw her alive on September 26th, 1918, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

1 Chronic Nephritis
2 131
3 Ch

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

CONTRIBUTORY (Secondary) Endocarditis Chronic (Duration) yrs. not known mos. ..... ds.

(Signed) G. Reinhold Pfeffer M. D.

Sept 27th 1918 (Address) 1452 N. 15 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. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence 1205a 8th N

19 PLACE OF BURIAL OR REMOVAL: Anna Ills

DATE OF BURIAL: Sept 28, 1918

20 UNDERTAKER: Frank Kettlage

ADDRESS: 907 Chouteau ave

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. ..... 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 September (Month) ..... (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from August the 1th 1918, to September 26th, 1918 that I last saw her alive on September the 26 1918, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

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

CONTRIBUTORY (Secondary) Endocarditis

..... (Duration) ..... yrs. not known mos. ..... ds.

(Signed) D. Reinhold Pessler M. D.

Sept 27th 1918 (Address) 1452 N. 15 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. ..... 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