

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

11536

1. PLACE OF DEATH

County.....

Registration District No. 781

File No.

Township.....

Primary Registration District No. 008

Registered No. 2310

City St. Louis (No.)

St.

Ward)

2. FULL NAME Virginia L. Saw

(a) Residence. No. 8217th Church Rd. St.

(Usual place of abode)

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Richard W. Saw

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

April 2, 1857

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ____ hrs. or ____ min.

61

11

1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Indianapolis

10. NAME OF FATHER

Wm. Riley

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

North Carolina

12. MAIDEN NAME OF MOTHER

Ann Starkoff

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

14.

INFORMANT (Address)

Richard W. Saw, 8217th Church Rd.

15.

FILED

19

Mar 6 Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 3 1919

17.

I HEREBY CERTIFY That I attended deceased from Jan 1 1919 to Mar 3 1919 that I last saw her alive on Mar 1 1919, and that death occurred, on the date stated above, at 2 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1919 Aortic insufficiency (duration) 7 yrs. 8 mos. ✓ da.

CONTRIBUTORY (SECONDARY)

Chronic Bronchitis

(duration) 2 yrs. ✓ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. ✓

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) D. A. Vandierfen M. D.
3/3 1919 (Address) 8513 Halleck Ave St. Louis

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Frieder's

March 5 1919

20. UNDERTAKER

ADDRESS

John Deiss

1507
Millwood Road

WRITE PLAINLY, WITH UNFAADING 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.

