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

1 PLACE OF DEATH

County: Jefferson

Township: Rock

or

Village:

or

City: (NO. ..... St. ..... Ward)

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

Registration District No. 423 — File No. 17398

Primary Registration District No. 5578 — Registered No. 26

2 FULL NAME Elisa Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: W

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

6 DATE OF BIRTH: March (Month) 26 (Day) 1848 (Year)

7 AGE: 71 yrs. 1 mos. 9 ds. — If LESS than 1 day, ... hrs. or ... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): St Louis County Mo

PARENTS

10 NAME OF FATHER: Gerhard Heihoff

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

12 MAIDEN NAME OF MOTHER: Katharina Jeide

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Brown

(Address) Kimmswick Mo

15 Filed May 7, 1919. W. J. F. Kirk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 5 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 3, 1919, to May 5, 1919, that I last saw h. alive on May 5, 1919, and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Cancer of Face

54

44

(Duration) 1 yrs. ... mos. ... ds.

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

(Signed) W. J. F. Kirk M. D.

May 7, 1919. (Address) Kimmswick Mo

*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: St Johannes Cemetery — DATE OF BURIAL: May 7, 1919

20 UNDERTAKER: John Koch — ADDRESS: Fenton Mo

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.

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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 occu
hospital or fa
give its NAME
of street and

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

17 I HEREBY CERTIFY, that I attended decease

....., 191....., to ....., 1

that I last saw h..... alive on ....., 1

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY (Secondary) .....

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

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Ca
(1) Means of Injury; and (2) whether Accidental, Suicidal or H

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr
or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos.

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

20 UNDERTAKER	ADDRESS

The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates

keepers who receive a definite salary), may be entered as *Housewife, Housework*, or *At-home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook; Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that

in the duties of the household only (not paid