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

25872

1 PLACE OF DEATH

County: St. Louis

Township ..... or Village ..... or City: Kirkwood (NO. 221 E. Main St.; ..... Ward)

Registration District No.: 78

Primary Registration District No.: 3037

File No. .....

Registered No.: 88

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

2 FULL NAME: Janet Peiree.

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: June 30 (Month) (Day) 1910 (Year)

7 AGE: 9 yrs. 1 mos. 5 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(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: C. C. Peiree

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

12 MAIDEN NAME OF MOTHER: Anne E. Brockett

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C. C. Peiree

(Address): Kirkwood

15 Filed 8/10, 1919. Dennavant C.E. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. 5 (Month) (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug. 4 - 6 ans, 1919, to Aug. 5 - 12 00 Aug. 1919 that I last saw h.. alive on Aug. 4 - 10 30 Jan. 1919 and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Diphtheria

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

CONTRIBUTORY (Secondary) .....

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

(Signed) W. H. Nash M. D.

8/6, 1919. (Address) Webster Groves

*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: Oak Hill Cemetery

DATE OF BURIAL: Aug. 6, 1919

20 UNDERTAKER: Louis F. Bopp.

ADDRESS: Kirkwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa...

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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 hospital or institution give its NAME instead of street and number.]

2 FULL NAME .....

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various occupations may be known. The

[Approved by U. S. Census and American Public Health Association.]

origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds. *Bronchopneumonia* (secondary)

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..... (Year)

17 I HEREBY CERTIFY, that I attended deceased fr

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

that I last saw h.....alive on ..... 191.....

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) ..... M.

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients 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** ..... 191.....

20 UNDERTAKER | **ADDRESS**