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

28569

1 PLACE OF DEATH

County: St Louis

Township ..... or Village ..... or City: Clayton Mo (NO. ....., ..... St.; ..... Ward)

Registration District No. 790 File No. .....

Primary Registration District No. 6033 Registered No. 68

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

2 FULL NAME: Jesse May Bellville

**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: May (Month) 22 (Day) 1862 (Year)

7 AGE: 57 yrs. 3 mos. 18 ds. If LESS than 1 day, ..... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Florissant Mo

PARENTS

10 NAME OF FATHER: Samuel James

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

12 MAIDEN NAME OF MOTHER: Virginia Robinson

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John W. E. Bellville
(Address): 116 Central Ave. Clayton, Mo

15 Filed 9/13, 1919 J. R. Sudduth Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: Sept (Month) 12 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April, 1919, to Sept 12, 1919, that I last saw her alive on Sept 12, 1919, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
23 A 78
(Duration) 1 yrs. 05 mos. ..... ds.

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

(Signed) John W. Sutter M. D.
Sept 12, 1919 (Address) 6437 Maple

*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: Central Ave
DATE OF BURIAL: Sept 15, 1919

20 UNDERTAKER: Louis H. Bopp
ADDRESS: Kirkwood

# 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 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

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

17 I HEREBY CERTIFY, that I attended deceased

....., 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) .....

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran 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

..... 1

20 UNDERTAKER

ADDRESS

As examples: (a) *Farm laborer, Laborer*; (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer*; *Coal mine*, etc. Women at home, who are engaged [illegible] of the household only (not paid *House-*

without surgical operation — [illegible]

VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and [illegible]