LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

39621

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11600

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME 11423 Laura Ellington

(a) Residence. No. 5241 Finish St. 7 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29 1904

7. AGE: Years 22 | Months 6 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 1428 1238
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

PARENTS
10. NAME OF FATHER: Chas Robirts
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Indiana
12. MAIDEN NAME OF MOTHER: Alpha Beckner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Indiana

14. INFORMANT: Hospital Information
(Address): City Hospital

15. FILED: DEC -8 1926 Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 8 1926

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1926 to Dec 8, 1926 that I last saw her alive on Dec 8, 1926 and that death occurred, on the date stated above, at 4 45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Post Operative Shock Operated Rt tube removed old ruptured tubal pregnancy (duration) that was secondarily infected

CONTRIBUTORY (SECONDARY) Colon Bacillus (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? yrs. DATE OF 11/7/26

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Operative

(Signed) W J Roche, M. D.

12/8, 1926 (Address) City Hosp

*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: Greenfield Ind | DATE OF BURIAL: Dec 11 1926

20. UNDERTAKER: Wm F Paschedag | ADDRESS: 2826 No Grand Rd

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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