

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

Do not use this space.

1. PLACE OF DEATH

County.....
 Township.....
 City St. Louis (No. 402 West Davis St)
 Registration District No. 1003
 Primary Registration District No. 1003

File No. 40405
 Registered No. 12457
 St. Ward

2. FULL NAME

Barbara Little
 (a) Residence. No. 402 West Davis 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. da. 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 Seth Little

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 4 - 1844

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
82 | 0 | 25

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) Home
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Unknown Heber

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

12. MAIDEN NAME OF MOTHER Not Ascertainable

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY) Not Ascertainable

14. INFORMANT Seth Little
 (Address) 402 West Davis St.

15. FILED DEC 31 1926 may 6 Starckoff REGISTERAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 19 26

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 26, to Dec 29, 19 26
 that I last saw her alive on Dec 22, 19 26, and that death occurred, on the date stated above, at 9-45-p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
Apoplexy
82 R (duration) yrs. mos. da.
 CONTRIBUTORY Arteriosclerosis
 (SECONDARY) (duration) 1 yrs. mos. da.

18. WHERE WAS DISEASE CONTACTED Home
 IF NOT AT PLACE OF RESIDENCE

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) A. W. Peters M. D.

Jan 5, 19 26 (Address) 601 Missouri Bldg

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Bellefontaine Jan 1 19 27

20. UNDERTAKER Frank Netlage ADDRESS 907 Chouteau

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.

