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

Do not use this space. ~~11~~

40424 L

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. ..... Registered No. 13

City St Louis (No. 5332 Northrup av St. ..... Ward)

2. FULL NAME Jefferin Mamie

(a) Residence. No. 5332 Northrup av St. 13 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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2nd 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60	—	29	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) Green Foundry Co

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Minnie Mamie
(Address)

15. FILED JAN - 1 1927 Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 31 1926

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1924, to 12/31, 1926 that I last saw him alive on 12/30, 1926, and that death occurred, on the date stated above, at 1 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Regurgitation

[illegible]

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

CONTRIBUTORY (SECONDARY) Cardio-Nephritis

Chronic (duration) ? yrs. ? mos. ? ds.

18. WHERE WAS DISEASE CONTRACTED

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [illegible], M. D

Jan 1, 1926 (Address) 5715 Southwest Blvd.

*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
Valhalla Cemetery	Jan 3rd 1926
20. UNDERTAKER	**ADDRESS**
Kriegshauser Und Co	4104 Manchester av

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.

5132 Shawley
5715 Sowesi Av.