

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

Do not use this space.

2691

**1. PLACE OF DEATH**

County.....

Registration District No. *793*

Township.....

Primary Registration District No. *110113*

City *St. Louis*

(No. *1921 Belt Ave.*)

File No. ....

Registered No. *255*

St. *2* Ward

**2. FULL NAME**

*Margaret Ashbrooke*

(a) Residence. No. *1921 Belt Ave.* Ward. *6*

(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. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*male*

**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**

*James Ashbrook*

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

*Dec. 12 - 1853*

**7. AGE**

YEARS *71*

MONTHS *0*

DAYS *25*

IF LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

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

*at home*

(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)

*England*

**10. NAME OF FATHER**

*John Webster*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*not known*

**12. MAIDEN NAME OF MOTHER**

*not known*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*not known*

**14.**

INFORMANT (Address)

*James Ashbrooke  
1921 Belt*

**15.**

FILED

*JAN -7 1927  
May B Starneoff*

REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

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

*Jan 7, 1927*

I HEREBY CERTIFY That I attended deceased from *Jan 2, 1927* to *Jan 7, 1927* (that I last saw him alive on *Jan 7, 1927* and that death occurred, on the date stated above at *2 am*.)

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Chronic myocarditis*

**CONTRIBUTORY (SECONDARY)**

*tooth infection from teeth* (duration) *2* yrs. mos. da. (duration) *10* yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *William D. Paper* M. D.

*Jan 7, 1927* (Address) *6424 Gaston*

\*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*

*1-9-1927*

**20. UNDERTAKER**

ADDRESS

*Wagoner*

*7621 Chiv*

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.

