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

Do not use this space.

3539

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. City Hosp St. ..... Ward)

File No. ..... Registered No. 1198

2. FULL NAME Aleen Stevenson

(a) Residence. No. 1103 Tyler St St., 26 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: 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 William Stevenson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 23 - 1867

7. AGE: Years 59 | Months 6 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 210

(b) General nature of industry, business, or establishment in which employed (or employer) 821

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Hugh McCracken

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

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT William Stevenson (Address) 1103 Tyler St.

15. FILED FEB - 3 1927 Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1927

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 4 - P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries (Haemorrhage of Brain) Collision Two Autos in City (duration) ..... ds.

CONTRIBUTORY (SECONDARY) Criminal Carelessness (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1 & C

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

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R. S. Vitt, M. D

2/3, 1927 (Address) Coroner C.C.

*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: Reno. Ills

DATE OF BURIAL: Feb. 4 1927

20. UNDERTAKER: Hy Leidner Und Co.

ADDRESS 1417 N. Market St.

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.