

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

Do not use this space.

6577

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis (No. *11288*)

City Hospital
St. Louis (Boyle) Boyle
1723 Exchange St.

File No. **1248**
Registered No.
St. (Ward)

2. FULL NAME

(a) Residence. No. *1723 Exchange* St. Ward.

Length of residence in city or town where death occurred *73* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

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) *July 2 - 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 *0* *0*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Stewardess*
(b) General nature of industry, business, or establishment in which employed (or employer). *131 9th*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Missouri*

10. NAME OF FATHER *Stan Louison*

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

12. MAIDEN NAME OF MOTHER *Oracyne*

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

14. INFORMANT (Address) *St. Louis, Mo. City Hospital*

15. FILED *SEP 4 1927* *Maub Stark* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 3 1927*

17. I HEREBY CERTIFY That I attended deceased from *Dec 13*, 19*26*, to *Jan 3*, 19*27*, that I last saw him alive on *Jan 3*, 19*27*, and that death occurred, on the date stated above, at *4:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Bronchomatous Nephritis
Ch. Myocarditis

CONTRIBUTORY (SECONDARY) *1290* (duration) yrs. mos. ds.

18. WHETHER WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH DATE OF

20. WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *W. M. Smith*, M. D.

13, 19*27* (Address) *City Hospital*

*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
St. Matthews Cemetery *Feb 5 1927*

20. UNDERTAKER ADDRESS
Weick Bros 2201 2d Grand Blvd

K. 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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. gles.