

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

Do not use this space.

6403

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis Mo (No. *1829²*) *Lafayette Ave*

File No.....

Registered No. **1602**

St.....

Ward.....

2. FULL NAME

(a) Residence. No. *1829²*

(Usual place of abode)

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.

(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)

Widowed

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

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

July 2 - 1852

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, _____ hrs. or _____ min.

74

7

12

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

14.

INFORMANT (Address)

Mrs. Masony 1829² Lafayette ave

15.

FILED FEB 16 1927

Max E. Staroboff Registrar

MEDICAL CERTIFICATE OF DEATH

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

Feb. 14 1927

17.

I HEREBY CERTIFY, That I attended deceased from *Feb. 2*, 1927, to *Feb. 14*, 1927 that I last saw *her* alive on *Feb. 13*, 1927, and that death occurred, on the date stated above, at *11 - a.m.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

Apoplexy

97

(duration) yrs. mos. *1* ds.

CONTRIBUTORY (SECONDARY)

Internal Sclerosis

(duration) yrs. mos. *12* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Harry C. Bohner, M.D.*

2/15, 1927 (Address) 315 - University Club

*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

Bethany

DATE OF BURIAL

Feb. 16 1927

20. UNDERTAKER

H. Z. Leidner and Co. 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.

