

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

Do not use this space.

6422

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **1623**

Township.....

Primary Registration District No. **11003**

Registered No. **1623**
Ward

City **St. Louis** (No. **St. Johns Hospital**) St.

2. FULL NAME

(a) Residence, No. **#4397, Mrs. Pherson, Ave.**
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. **19** 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) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Jeremiah R. French**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan, 20th, 1839**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
88. X. 26.

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) **Schaneelsville, N. Y.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Walter Switz**

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

12. MAIDEN NAME OF MOTHER **Elizabeth Robin**

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

14. INFORMANT **O. E. French**
(Address) **#4397 Mrs. Pherson, Ave.**

15. FILED **16 1927** **Max B. Starkeoff**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 16th, 1927**

17. I HEREBY CERTIFY, That I attended deceased from **2/14**, 19**27**, to **2/16**, 19**27**, that I last saw him **alive** on **2/14/27**, 19**27**, and that death occurred, on the date stated above, at **1727**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
**Fracture of R. Leg
due to a fall in
bat room accident**
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Arteriosclerosis
of family**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
185
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **all tests**
(Signed) **Chas. Johnson**, M. D.
2/16, 19**27** (Address) **Schaneelsville**

*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 **Springfield, Mo.** DATE OF BURIAL **2-17-1927**

20. UNDERTAKER **Chas. R. Rupton**
ADDRESS **#444 9th Street**

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.

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