

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

Do not use this space.

6616

1. PLACE OF DEATH

County.....

Registration District No. **1791**

Township.....

Primary Registration District No. **1003**

City **St. Louis**

(No. **City Hospital**)

File No.

Registered No. **1842**

St.

Ward)

2. FULL NAME

(a) Residence. No. **3733 Laclède St.**

(Usual place of abode)

21. Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **1** 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 or (or) WIFE of

wife of Mr. J. Wilson

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

Dec 18 - 1873

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

53

4

4

8. OCCUPATION OF DECEASED

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

Stuccoer

(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)

Indiana

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14. INFORMANT

(Address)

St. Louis, Mo. City Hospital

15.

FILED **23 1927**

Marie Starceoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 22 1927

17.

I HEREBY CERTIFY That I attended deceased from **June 20**, 19**27**, to **June 22**, 19**27**, that I last saw him alive on **June 21**, 19**27**, and that death occurred, on the date stated above, at **11:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia of Breast
50

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

47

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

18. DID AN OPERATION PRECEDE DEATH

DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

W. M. Smith, M. D.

73. 1927 (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

Lucernus, Ind.

7/23 1927

20. UNDERTAKER

ADDRESS

W. C. Laughlin

1631 Ma

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.

RECORD

Wilson