

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

Do not use this space.

✓ 8769

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... **1003**
City **St. Louis** (No. **City Hospital**)
4024 Mary Kern

File No.....
Registered No. **2303**
St..... Ward.....

2. FULL NAME

(a) Residence. No. **4218 Broadway St.** Ward. **11**
(Usual place of abode)

Length of residence in city or town where death occurred **4** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
abt. 55				

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

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

10. NAME OF FATHER **John Kern**

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT **E. Roman**
(Address) **City Hospital**

15. **FEB 23 1927** **Paul B. Starvo**
FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from **Jan 18 1927** to **Jan 16 1927** that I last saw her alive on **Jan 16 1927** and that death occurred, on the date stated above, at **3:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Cardiac Disease
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **None**
(duration) yrs. mos. da.

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

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) **P. Smith** M. D.
1/27 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 **Perryville Mo** DATE OF BURIAL **Mar 1 1927**

20. UNDERTAKER **Cullman Bros.** ADDRESS **17104 Grand**

...WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003

File No. 2001
Registered No. (2000)
St. Ward

2. FULL NAME

(a) Residence. No. St. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 19. May 6 1927
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 26 1927

17. I HEREBY CERTIFY, That I attended deceased from to 19..... and that I last saw him alias on 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic cardiac disease

Chronic Cardiac Disease
CONTRIBUTORY INFORMATION given over (duration) yrs. mos. da.
Phone by Dr. R. M. Smith
Rev. of W. S. 4-15-27

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed)....., M. D.
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

N. B.—Every entry of in case of death should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. OCCUPATION IS VITAL

WITH UNFADING INK—FOR BUREAU OF VITAL STATISTICS

5-6964