

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

Do not use this space.

13390

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City *St. Louis Mo.* (No. *3302 California Ave.*)

File No.....

Registered No. *3702*

St. Ward)

2. FULL NAME

(a) Residence. No. *3302 California* *24* Ward.

(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

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

Female | *White* | *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 29-1926*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>0</i>	<i>11</i>	<i>17</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *None*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER *Edw. Woodley*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis Mo.*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Helen Grotsch*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis Mo.*
 (STATE OR COUNTRY)

14. INFORMANT *Edw. Woodley*
 (Address) *3302 California Ave*

15. *APR 18 1927*
 FILED *19* *Maub Starloff*

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from *April 16, 1927* to *April 16, 1927*, and that I last saw her alive on *April 16, 1927*, and that death occurred, on the date stated above, at *4 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

10 9/27
Broncho Pneumonia
Primary (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *100%* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, *No*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*

(Signed) *B. W. Kippell*, M. D.

4/16, 1927 (Address) *3772 5a Broadway.*

*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

Bethlehem Cem. | *April 20 1927*

20. UNDERTAKER | ADDRESS
Ziegenhein Bros. 2623 Cherokee

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.

RECORDING INFORMATION THIS IS A PERMANENT RECORD

