LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

13535

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3869

City St. Louis, Mo. (No. 2328 Hebert St. ..... Ward)

2. FULL NAME Louise A. Ladd

(a) Residence. No. 2328 Hebert St., 20 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. 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	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27 - 1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	1	24	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn.

PARENTS

10. NAME OF FATHER Thos. J. Biggers

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

12. MAIDEN NAME OF MOTHER Mary McCrory

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

14. INFORMANT Sherman Ballentine
(Address) 2328 Hebert St.

15. FILED [illegible] Mar[illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 21st, 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1925, to 4-21-, 1927 that I last saw her alive on 4-21-, 1927, and that death occurred, on the date stated above, at 4:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris
(duration) 2 hrs. mos. ds.

CONTRIBUTORY (SECONDARY) age
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ——
DID AN OPERATION PRECEDE DEATH? No DATE OF ——
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ——
(Signed) W F Dunn, M. D
, 19 (Address) 5665 Delmar Ave

*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 Mo. Crematory DATE OF BURIAL 4-23-1927

20. UNDERTAKER ADDRESS

WRITE PLAINLY 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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CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...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. 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)

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. [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Apr 21, 1927 to ....., 19.....
that I last saw her alive on Apr. 21, 1927, and that death occurred, on the date stated above, at 4 10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoras

(duration) 2 hrs. mos. ds.

CONTRIBUTORY (SECONDARY) age

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) T F Dunn, M. D

, 19 (Address) 5655 Delmar

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