

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

Do not use this space.

16301

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo*

(No. *4539 St. Ferdinand av* St. *11* Ward)

File No.

Registered No. *4170*

2. FULL NAME

Nellie E. Gaddell

(a) Residence. No. *4539 St. Ferdinand St.* *11* 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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

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

March 27 - 1883

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

44

1

4

8. OCCUPATION OF DECEASED

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

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Charles

(STATE OR COUNTRY)

MO

10. NAME OF FATHER

Jacob Gaddell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

14.

INFORMANT

(Address)

*Joseph Kampmann
4539 St. Ferdinand*

15.

FILED

*3 1927 Mar. 8 Staroff
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

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

May 1 1927

17.

I HEREBY CERTIFY, That I attended deceased from *Apr 22*, 19*27*, to *May 1*, 19*27*, that I last saw h. *alive* on *May 1*, 19*27*, and that death occurred, on the date stated above, at *2:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Solar Pneumonia

CONTRIBUTORY (SECONDARY)

108 *1010* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Emmett Byers*, M. D.

May 2 1927 (Address) *3824 N. 11th St*

*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

Graves Cemetery *May 4 1927*

20. UNDERTAKER

ADDRESS

Hy. Lidner, Und. Co *1417 N. Market*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

