

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

Do not use this space.

16612

1. PLACE OF DEATH

County..... Registration District No. **791**

Township..... Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.....

Registered No. **4511**

St..... Ward.....

2. FULL NAME

(a) Residence. No. **5607^{1/2} Theodosia** St. **6** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **65** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4. COLOR OR RACE

White

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

widowed

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

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

Sept Unknown

7. AGE

abt. 78

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

Homeowner

9. BIRTHPLACE (CITY OR TOWN)

New York

10. NAME OF FATHER

Ben Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

N.Y.

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

N.Y.

14. INFORMANT

(Address)

*St. Louis Infirmary
E. Moran
City Hospital*

15. FILED

*May 6 1927
Maulb. Starkeoff
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 12 1927*

17. I HEREBY CERTIFY, That I attended deceased from *May 9 1927* to *May 13 1927*

that I last saw *her* alive on *May 13 1927* and that death occurred, on the date stated above, at *10:30 AM*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Solar Pneumonia
108*

CONTRIBUTORY (SECONDARY)

101A

18. WHERE WAS DISEASE CONTRACTED

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

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

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

*(Signed) Thos. W. Miller, M.D.
1/4, 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

balcony May 16 1927

20. UNDERTAKER

ADDRESS

Wm. Leidner 11417 S. Market

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.

Gorman