

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

Do not use this space.

19516

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. Isolation Hosp.)..... St. _____ Ward _____

File No. _____
 Registered No. 5203
 St. _____ Ward _____

2. FULL NAME

Shelma Holmes
 (a) Residence, No. 2043 Park St. 22 Ward _____

(Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 1 mos. 4 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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/17/11

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>15</u>	<u>11</u>	<u>16</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work house work 10
 (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 Bert Holmes

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

12. MAIDEN NAME OF MOTHER Lulu Carmen

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

14. INFORMANT Lorraine Kerner
 (Address) Isolation Hosp.

15. FILED JUN -1 1927 Mar. C. Starkoff
 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-3-1927

17. I HEREBY CERTIFY, That I attended deceased from 5/31, 1927, to 6/3, 1927, that I last saw him alive on 6/3, 1927, and that death occurred, on the date stated above, at 11-7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Menigitis Simple
(Streptococcic)
 (duration) yrs. _____ mos. 4 ds.
 CONTRIBUTORY Lobar Pneumonia
 (SECONDARY) (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 2043 Park
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy with
 (Signed) Dr. J. H. ... M/D
6/4, 1927 (Address) 600 Arenal St. Del Rio

*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 Witterbergs Ma DATE OF BURIAL June 7, 1927

20. UNDERTAKER McLaughlin ADDRESS 1631 Mission

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.

WRITING IN THESE SPACES IS A PERMANENT RECORD

10/10/10