

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

Do not use this space.

19988

1. PLACE OF DEATH

County.....

Registration District No.....

791

File No.....

Township.....

Primary Registration District No.....

1003

Registered No. | 5752

City..... *St. Louis, Mo.*

(No.)

City..... *Sanitarium*

St. Ward)

2. FULL NAME *Margaret Peay*

(a) Residence, No. *212 N. Clay* ... *13* Ward. *Kirkwood, Mo.*
(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)

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec. 21, 1910.*

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

16

6

0

8. OCCUPATION OF DECEASED

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

Unknown ²⁸/₅₃

(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)

St. Louis Missouri

10. NAME OF FATHER

August Peay

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Belleville Illinois

12. MAIDEN NAME OF MOTHER

Edna Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

14.

INFORMANT (Address)

Joseph Kohler 15300 W. Main St.

15.

FILED

JUN 22 1927

mauve Starnesoff

REGISTERED

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6/21/27* 19

17.

I HEREBY CERTIFY, That I attended deceased from *7/21/25* 19....., to *6/21/27* 19....., and that I last saw him alive on *6/21/27* 19....., at *7:25* m. death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis of Skin and Subcutaneous cellular tissue (Face)

CONTRIBUTORY (SECONDARY)

360

(duration) yrs. *3* mos. *3* ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

19. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical and laboratory*

(Signed) *Joseph Kohler* M. D.

6/21/27, 19 (Address) *5300 W. Main 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

Mt. Carmel Belleville Ill June 23 1927

20. UNDERTAKER

ADDRESS

Thos. Burke

East St Louis Ill

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.

