

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

791

20181

Township.....

Primary Registration District No.....

1003

File No.....

City..... *St. Louis*

(No. *5621 Dale Ave*)

Registered No. **5956**

St. Ward

2. FULL NAME

Dorothy Mc Gates

(a) Residence. No. *5621 Dale Ave* St. *4* Ward.

(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) *June 9, 1908*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 0 18

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 *At home*

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY)

10. NAME OF FATHER *James Mc Gates*

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

12. MAIDEN NAME OF MOTHER *Ida Mc Gates*

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

14. INFORMANT *Velda Mc Gates*
(Address) *5621 Dale Ave*

15. FILED *IN 29 1927* *Mar 6 Starcoff*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 27 1927*

17. I HEREBY CERTIFY, That I attended deceased from *May 19 1927* to *June 27 1927* that I last saw *alive on June 24 1927*, and that death occurred, on the date stated above, at *3:54 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia (Bacterial)
34 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *38* (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? *Physician*
(Signed) *H. B. Orlew, M. D.*

(Address) *1446 S Grand*

*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

New St. Marcus

6-29-27

20. UNDERTAKER

ADDRESS

Kreighbaum & Co. Manchester

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.

DEPARTMENT RECORD

At. Alper
Grand North of Park
4-8 P.M.