

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

Do not use this space.

22754

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No. ....  
 Township..... Primary Registration District No. 1003 Registered No. 16411  
 City St. Louis Mo. (No. Le city Hospital) St. .... Ward)

**2. FULL NAME**

Jeanne Le Grand

(a) Residence No. 2802 Chouteau Av. 12 Ward. (If nonresident give city or town and State)  
 (Usual place of abode)

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

**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 OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 26-1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
6 | 4 | 17 |

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work nile 1000  
 (b) General nature of industry, business, or establishment in which employed (or employee) "  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Albert Le Grand

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

12. MAIDEN NAME OF MOTHER Cara Bullinger

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

14. INFORMANT Mr Albert Le Grand  
 (Address) 2802 Chouteau Av.

15. FILED JUL 13 1927 19..... Maub Starroff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/13 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at 8-35-91 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
M.M.A. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) M.M.A. (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? y

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
 (Signed) Deputy Coroner

\*State the DISEASE CAUSING DEATH, or in cases 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

Cape Girardeau Mo. July 13 1927

20. UNDERTAKER ADDRESS

E. J. Schmur 3125 Lafayette Av.

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.

