

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

Do not use this space.

22839

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township *Isolation Hospital* Primary Registration District No. **1003**
 City *St. Louis, Mo.* (No.) (If nonresident give city or town and State)

File No.
 Registered No. **6503**
 St. Ward)

2. FULL NAME

Lorraine Schultz
 (a) Residence. No. *1864 Cass Ave.* St. **27** Ward.
 (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) *married*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 24, 1909*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 4 21

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *House wife*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY) *Ala.*

10. NAME OF FATHER *Melittus Bickard*

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

12. MAIDEN NAME OF MOTHER *Fannie Taylor*

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

14. INFORMANT *Lorraine Kroner*
 (Address) *Isolation Hospital*

15. FILED *17 1927* 19. *Maxlo Starroff*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7-15 1927*

17. I HEREBY CERTIFY, That I attended deceased from *7/13*, 19*27*, to *7/15*, 19*27*, that I last saw her *alive on 7/15, 1927*, and that death occurred, on the date stated above, at *9:00 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis, Simple
79 A. (Staphylococcus)
 (duration) yrs. mos. *3* ds.

CONTRIBUTORY (SECONDARY) *79 A.*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? *1864 Cass Ave.*

19. DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....
 WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Culture of Guttus*
 (Signed) *Chas. H. White, M.D.*
7/15, 1927 (Address) *700 Anselm St. St. Louis, Mo.*

*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 *St. Matthews* DATE OF BURIAL *July 17 1927*

20. UNDERTAKER *Central Ind. Co.* ADDRESS *189 Cass*

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.

