

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

Do not use this space.

23096

1. PLACE OF DEATH

County.....

Registration District No. 31

Township.....

Primary Registration District No. 1003

City St. Louis, Mo. (No. Isolation Hospital)

File No.

Registered No. 6786

St. Ward)

2. FULL NAME Lois Kinderman

(a) Residence, No. 4459 Shaw St. 17 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. 5 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 OF (OR) WIFE OF single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-19-20

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>7</u>	<u>2</u>	<u>5</u>	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

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

10. NAME OF FATHER Cornelius Kinderman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Alma King

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

14.

INFORMANT A. Kroger
(Address) ISOLATION HOSPITAL

15. FILED JUL 26 1927 19 Mar 6 Starkoff
REGISTER

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 7/24 1927

17. I HEREBY CERTIFY, That I attended deceased from 7/7, 1927, to 7/24, 1927, that I last saw him alive on 7/24, 1927, and that death occurred, on the date stated above, at 3:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
Diphtheria, Pharyngeal & Laryngeal
Post-Diphtheritic Paralysis
of Left Arm & leg.
(duration) yrs. mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED 4459 Shaw
IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF No.
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? St. Gallie
(Signed) John T. Ash, M. D.
7/24, 1927 (Address) 100 Arsenal 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 Halbaha Cem. DATE OF BURIAL 7-27-1927

20. UNDERTAKER Peety Bros. 3029 Lafayette

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.

