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

Do not use this space.

25405

OCT 2 1927

1. PLACE OF DEATH

County: St. Louis

Township: CARONDELET

City: ..... (No. ..... St. ..... Ward)

Registration District No. 1123

Primary Registration District No. 248

File No. .....

Registered No. 301

2. FULL NAME Ethel Westcott

(a) Residence. No. 4062 Lindell Bl. St., ... 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: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Howard Wescott

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 9 - 1902

7. AGE: Years 25 | Months 10 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER: Sam Salee

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

12. MAIDEN NAME OF MOTHER: Lora Knoehke

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): St. Louis
(STATE OR COUNTRY): .....

14. INFORMANT: Hospital Records
(Address): .....

15. Aug. 15 - 27 L. C. Obrod
FILED ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): August 15 1927

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to Aug. 15, 1927, that I last saw h. ex. alive on Aug. 15, 1927, and that death occurred, on the date stated above, at 4:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CHRONIC PULMONARY TUBERCULOSIS

2 yrs

25 (duration) yrs. ..... mos. ..... ds. I do not Know

CONTRIBUTORY (SECONDARY) TUBERCULOUS ENTERITIS

..... (duration) yrs. ..... mos. ..... ds. I do not Know

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? I do not Know

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Sputum.

8/15, 1927 (Signed) Leonna Schlenker, M. D.
(Address) 3515 S. Grand Bl.

*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: New St. Marcus — DATE OF BURIAL: 8/16 1927

20. UNDERTAKER: C. R. Lipton — ADDRESS: 4449 Olive

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE PRESCRIBED BY LAW

1. PLACE OF DEATH

County: St. Louis — Registration District No. 1123 — File No.

Township: Carondelet — Primary Registration District No. 6248 E — Registered No. 301

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Ethel Westcott

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 9-1902

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS

10. NAME OF FATHER .....

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

12. MAIDEN NAME OF MOTHER .....

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

14. INFORMANT .....
(Address)

15. Oct. 14, 19 27 FILED ..... L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 15 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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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
	19
20. UNDERTAKER	**ADDRESS**

SUPPLEMENTARY

S-24405