

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

Do not use this space.

25456

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

File No. **46**

Township.....

Primary Registration District No. **1003**

Registered No. **7004**

City **St. Louis** (No. **City Hospital** St. **Ward**)

**2. FULL NAME**

**Flora Elsie King**

(a) Residence. No. **3691 Kaelede** St., **19** Ward.

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. (If nonresident give city or town and State)

**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) **Dec 8-1895**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<b>31</b>	<b>7</b>	<b>24</b>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **None**  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Bourbon Mo** (STATE OR COUNTRY)

10. NAME OF FATHER **Albert King**

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

12. MAIDEN NAME OF MOTHER **Lizzie Smith**

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

14. INFORMANT **Lizzie Jane King** (Address) **3691 Kaelede**

15. FILED **AUG - 3 1927** **Maub Staroff** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 2 1927**

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw b..... alive on ..... 19....., and that death occurred, on the date stated above, at **1 20 P.** m.

THE CAUSE OF DEATH: WAS AS FOLLOWS:

**Typical Poisoning**  
**1120 Suicide** (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **1120**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? **R. O. A. M. I.**  
 (Signed) **Mr. J. Corcoran** 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 **Walthalla Cem.** DATE OF BURIAL **Aug 3 1927**

20. UNDERTAKER **Dehmsen Harrod** ADDRESS **1905 Union**

K. E.—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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

