

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

Do not use this space.

25496

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.
Registered No. **7081** St. Ward)

2. FULL NAME

(a) Residence. No. **3828a Embury St.** 11 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **38** 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) married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John J. Taylor				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7 1888				
7. AGE	YEARS 38	MONTHS 8	DAYS 8	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Factory**

(b) General nature of industry, business, or establishment in which employed (or employer) **Alm. Hospital**

(c) Name of employer **St. Louis Co**

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

10. NAME OF FATHER **Aug. J. DeLamun**

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

12. MAIDEN NAME OF MOTHER **Augusta Rhein**

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

14. INFORMANT **Robert**
(Address) **City Hospital**

15. FILED **Nov 1 1927**
19.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 4 1927**

17. I HEREBY CERTIFY, That I attended deceased from **June 17 1927**, to **Aug 4 1927**, and that I last saw him alive on **Aug 4 1927**, and that death occurred, on the date stated above, at **8:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of cervix uteri

CONTRIBUTORY (SECONDARY) **46**
(duration) yrs. mos. da.

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) **Edmund R. Shride, M.D.**
8/4 1927 (Address) **City Hospital**

*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 **Calvary Cemetery** DATE OF BURIAL **Aug 6 1927**

20. UNDERTAKER **W. Collins** ADDRESS **1039 N. Grand**

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.

Taylor