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

Do not use this space.

25828

File No. .....

Registered No. 7438

1. PLACE OF DEATH

County ..... Registration District No. 701

Township ..... Primary Registration District No. 1003

City St Louis (No. 1437 a N 21st St ..... St. ..... Ward)

2. FULL NAME Minnie May Looby

(a) Residence. No. ..... St., N.J. 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)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	36	—	—	

8. OCCUPATION OF DEECEASED

(a) Trade, profession, or particular kind of work At Home

(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) Ills

PARENTS

10. NAME OF FATHER Frank Oderkirk

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

12. MAIDEN NAME OF MOTHER Lizzie Tousal

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

14. INFORMANT William Looby
(Address) 1437 a N 21st St

15. FILED AUG 19 1927, 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/18 1927

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to Aug 18, 1927 that I last saw h. alive on Aug 17, 1927, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis
A2A 88 B
1160 8 B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Extravasa pyorrosa
..... (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) C. A. Hueter M.D.
Aug 18, 1927 (Address) 2206 Howard 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 Calvary — DATE OF BURIAL 8-20 1927

20. UNDERTAKER Arthur J Donnelly — ADDRESS 2039 Walsh St

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.

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

Dr Henke
2206 Howard 2
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