

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

Do not use this space.

25932

1. PLACE OF DEATH

County..... Registration District No. **701**
Township..... Primary Registration District No. **1003**
City St. Louis (No. City Hospital)

File No.
Registered No. : **7548**
St. Ward)

2. FULL NAME

Virginia Danner
(a) Residence, No. 5237 Alabama Ave Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 27 1904

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	23	4	26	

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

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Philip Danner
(Address) 5237 Alabama Ave

15. FILED 21 1927 Mar 6 Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 22 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... 10A

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
82A
N.M.A. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. da.

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

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) W. H. Rath

824 1927 (Address) Deputy Coroner
*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Missouri Crematory DATE OF BURIAL Aug 25 1927

20. UNDERTAKER Wacker-Heldorff ADDRESS 2331 S Bldg

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.

