

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

Do not use this space.

26121

1. PLACE OF DEATH

County.....
 Township.....
 City.....
 Registration District No. **791**
 Primary Registration District No. **1003**
 (No. **6641 Vermont Ave**)

File No.....
 Registered No. **7749**
 St..... Ward.....

2. FULL NAME

(a) Residence. No..... St..... Ward.....
 (Usual place of abode)
 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 **Male** 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 8, 1917**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	10	5	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Schoolgirl**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Blow School**
 (c) Name of employer

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

10. NAME OF FATHER **Jas L. McElworell**

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

12. MAIDEN NAME OF MOTHER **Louise B. McElworell**

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

14. INFORMANT **Jas L. McElworell**
 (Address) **6641 Vermont Ave**

15. FILED **21** **1927** **max 6 Startloff**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 30 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 6**, 1927, to **Aug 30**, 1927 that I last saw him alive on **Aug 29**, 1927, and that death occurred, on the date stated above, at **8:30 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Organic Heart Disease
Mitral insufficiency & stenosis
Chronic
 (duration) yrs. **8** mos. **-** ds.
 CONTRIBUTORY (SECONDARY) **Chronic Myocarditis anasarca**
Ca (duration) yrs. **6** mos. **-** ds.

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

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

20. WAS THERE AN AUTOPSY? **No.**

21. WHAT TEST CONFIRMED DIAGNOSIS? **Clinical only**
 (Signed) **W. E. Coffman**, M. D.
 , 19 (Address) **6607 Va. Ave.**

*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.

22. PLACE OF BURIAL, CREMATION, OR REMOVAL **Valhalla** DATE OF BURIAL **Sept 1 1927**

23. UNDERTAKER **Hoffman & Co** ADDRESS **7814 So. 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.

DEPARTMENT RECORD

