

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

Do not use this space.

27131

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township Law Primary Registration District No. \_\_\_\_\_ Registered No. 3382  
 City R. E. Mo. (No. Research Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

Mollie M. Breakers  
 (a) Residence. No. 2027 Mmgable St. \_\_\_\_\_ 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. 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 Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm D. Breakers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-23-188

7. AGE YEARS MONTHS DAYS II LESS than I day, hrs. or min.  
47 | 6 | 9 | \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(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) St. Clair  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Jno. Hammond

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Agnes Rogers

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

14. INFORMANT Wm D. Breakers  
 (Address) 2602 Olive St.

15. FILED 9-3-27 M M Crowe  
 REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-2-1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 to Sept 2 1927  
 that I last saw \_\_\_\_\_ alive on Sept 2 1927 and that death occurred, on the date stated above, Sept 2 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis  
108  
9:30

(duration) yrs. mos. da.

CONTRIBUTORY Hypostatic Pneumonia  
 (SECONDARY) Lobar  
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 1010

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) D.R. Black, M. D.

9/3, 1927 (Address) 743 Lathrop Bldg.

\*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 Forest Hill DATE OF BURIAL Sept-3-1927

20. UNDERTAKER Mrs. C. L. Forster ADDRESS R. E. Mo.

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.

JUL 22 1979