

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. **28445**

Registered No. **7973**

2. FULL NAME

(a) Residence. No. *906 Chambers St.* St. *26* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *36* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Wedded*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 6 1927*

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

17. I HEREBY CERTIFY That I attended deceased from *Sept 19 1927* to *Sept 6 1927* that I last saw him alive on *Sept 6 1927* and that death occurred, on the date stated above, at *7:00 a.m.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 16 - 1870*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *57 | 6 | 10*

*Acute Myocarditis
Chronic myocarditis*

8. OCCUPATION OF DECEASED

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

903 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) *Myocarditis #103*
No Tobar or Broncho
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*

8. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

10. NAME OF FATHER *John Jones*

9. WAS THERE AN AUTOPSY.....

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

WHAT TEST CONFIRMED DIAGNOSIS.....

12. MAIDEN NAME OF MOTHER *Martha Kelly*

(Signed) *J. J. [Signature]* M. D.

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

(Address) *City Hospital*

14. INFORMANT (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.

15. FILED *SEP - 8 1927* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary Cem* DATE OF BURIAL *Sept 9, 1927*

20. UNDERTAKER *Alfred Lillo 2707 91 Grand* ADDRESS

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.

Kusty.