

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

Do not use this space.

28484

File No. 8014
Registered No. 8014
St. _____ Ward _____

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis (No. _____)

Registration District No. 791
Primary Registration District No. 1003

2. FULL NAME

Albertine Dehites

(a) Residence No. 1234 Chouteau Ave 22 Ward.

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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22nd 1912

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	1	8	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(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

10. NAME OF FATHER Elias Dehites

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Beama Beasly

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

14. INFORMANT Elias Dehites
(Address) 1234 Chouteau Ave

15. May C. Stinking
FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8th 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 11:55 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Fracture of skull
fall from porch
CONTRIBUTORY (SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED Accident

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Paul Dever M.D.
9/9, 1927 (Address) Dep Coroner

*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 St. Peter & Paul DATE OF BURIAL Sept 10th 1927

20. UNDERTAKER Mo Polk ADDRESS 2287 Grand

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.

