

**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 Mo** (No. **1430**)

Menard

File No. **28608**

Registered No. **8141**

St. **8141**

Ward

2. FULL NAME **Lina Bennett**

(a) Residence. No. **1430 Menard** St. **23** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **5** 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 (write the word)

Married

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

H. D. Bennett

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

Aug 20 1892

7. AGE

YEARS **35**

MONTHS **0**

DAYS **22**

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Wagner Co. Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

G. H. Bennett

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Nancy Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT

(Address)

**M. S. Bennett
1430 Menard St. St Louis Mo**

15.

FILED

SEP 13 1927

May C. Stanley

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

Sept 12 1927

17.

I HEREBY CERTIFY That I attended deceased from **July 20 1927** to **Sept 12 1927** that I last saw her alive on **Sept 12 1927**, and that death occurred, on the date stated above, at **8:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chorea cystitis

18. WHERE WAS DISEASE CONTRACTED

1247 D 917 (duration) 2 yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **Aug 4 1927**

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Physical**

(Signed) **H. L. Meador** M. D.

9-13-27 Address **3440 N. 9th St. St Louis Mo**

*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

DATE OF BURIAL

Williamsville Mo

9-13 1927

20. UNDERTAKER

ADDRESS

Weick Bros 2201 So 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.

STATE OF MISSOURI, WITH UNPAID INK—THIS IS A PERMANENT RECORD

