

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

Do not use this space.

28610

1. PLACE OF DEATH

County.....
Towship.....
City *St. Louis* Registration District No. **791**
Primary Registration District No. **1002**
Griffin Hospital

File No.
Registered No. **8143**
St. Ward)

2. FULL NAME

(a) Residence. No. *6301 Vermont* St. Ward.
(Usual place of abode)
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. (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) *Widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 19 1851*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *75 10 25*
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *House Work*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Pittsfield*
(STATE OR COUNTRY) *Ill*

10. NAME OF FATHER *Robt. Davis*

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

12. MAIDEN NAME OF MOTHER *Marie Hagerty*

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

14. INFORMANT *Edw. Kesterrelt*
(Address) *4047 Botanical Ave*

15. FILED *13 102* REGISTRAR *Max C. Starnoff*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 13 1927*
17. I HEREBY CERTIFY, That I attended deceased from *Sept 3* 1927, to *Sept 13* 1927, that I last saw him alive on *Sept 12* 1927, and that death occurred, on the date stated above, at *SMA* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
132A
Cerebral Hemorrhage
Apoplexy
(duration) yrs. mos. *10* da.
CONTRIBUTORY (SECONDARY) *arteriosclerosis & nephritis*
(duration) yrs. *10* mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF BIRTH *6301 Vermont Ave*
DID AN OPERATION PRECEDE DEATH? *no* DATE OF *no*
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *A. Schlossstein* M. D.
Sept. 13, 1927 (Address) *3153 Longfellow Pl*

*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 *Grain City Ill* DATE OF BURIAL *Sept. 14 1927*

20. UNDERTAKER *Wm Schumacher* ADDRESS *3013 Meramec*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

X. 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.

