

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

Do not use this space.

28770

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1008

City *St. Louis Mo* (No. *2611 1/2 N. 19th St*)

File No.....

Registered No.....

8311

St. Ward)

2. FULL NAME

Ruby Highland

(a) Residence. No. *2611 1/2 N. 19th St* St., *26* Ward.

(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female

White

Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 10. 1897*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

30

-

7

8. OCCUPATION OF DECEASED

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

Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

10. NAME OF FATHER

Frank Beck

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ills.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Anna Patterson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ills.

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

*James Highland
2611 1/2 N. 19th St*

15.

FILED

SEP 19 1927

My C. Staroboy

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 17 - 1927*

17.

HEREBY CERTIFY, That I attended deceased from *Sept 11*, 1927, to *Sept 17*, 1927 that I last saw h. *ea* alive on *Sept 17*, 1927, and that death occurred, on the date stated above, at *2:00 p* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Puerperal Peritonitis

145H

CONTRIBUTORY (SECONDARY)

146

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *R. L. Hild*, M. D.

Sept 19 27 (Address) *3700 Maple*

*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

Memorial Park

Sept 19 1927

20. UNDERTAKER

ADDRESS

Hy Leidner Und Co N. Market St

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.

IMPROVEMENT RECORD

1002

1002

1002