

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

Do not use this space
5521

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003** File No.....
City **St. Louis** (No. **Bethesda Hospital**) Registered No. **8495**
St. J. Ward

2. FULL NAME

Virginia E. Surrency
(a) Residence. No. **1320 79 Big Bend Rd.** Ward. **St. Louis 20, Mo.**
(Usual place of abode) (If nonresident give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 18th 1926**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
11 4
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **None** 1196
(b) General nature of industry, business, or establishment in which employed (or employer) 158
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)
10. NAME OF FATHER **Lester A. Surrency**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ohio**
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER **Mae A. Deuba**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)

14. INFORMANT **Lester A. Surrency**
(Address) **1320 79 Big Bend Rd.**

15. **SEP 23 1927** **Maud Hawley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sep. 22 1927**
17. I HEREBY CERTIFY That I attended deceased from **Sep. 19 1927** to **Sep. 21 1927** (that I last saw h. a. alive on **Sep. 21 1927**) and that death occurred, on the date stated above, at **2 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Gastro Enteritis
1196 (duration) yrs. mos. **3** da.
CONTRIBUTORY **Antecedent**
(SECONDARY) **Erysipelas**
(duration) yrs. mos. **14** da.

18. WHERE WAS DISEASE CONTRACTED **County**
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **E. W. Saunders**, M. D.
9-23-27 (Address) **1571 S. Grand**
*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 and Pauls** DATE OF BURIAL **9-24 1927**

20. UNDERTAKER **Arthur J. Donnelly** ADDRESS **2039 Mark 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.

THIS IS A PERMANENT COPY

Lester H. ...

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. **8427**
City..... (No. **Bethesda Hosp.** St. Ward)

2. FULL NAME

Virginia B. Syrett
(a) Residence. No..... St..... Ward..... *St. Louis Co.*
(Usual place of abode) (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 **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
11 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)..... CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos. ds.
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *St. Louis* (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

NOV 17 1927 FILED *Mar 6 Staroff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 22 19 27*

17. I HEREBY CERTIFY That I attended deceased from....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*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

20. UNDERTAKER

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-2892