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

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.

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

Do not use this space.

31595

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. 3241 Knapp St. St. ..... Ward)

File No. ..... Registered No. 8931

2. FULL NAME Minnie Dowell

(a) Residence. No. 3241 Knapp St. St., 26 Ward. (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: 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) Feb. 10 - 1883

7. AGE: Years 44 | Months 7 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky.

PARENTS

10. NAME OF FATHER: M. F. Shuyler

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

12. MAIDEN NAME OF MOTHER: Margaret Bates

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

14. INFORMANT: Margaret Dowell (Address) 3241 Knapp St.

15. FILED OCT -7 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 5th 1927

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1926 to Oct 5th, 1927 that I last saw her alive on Oct. 4th, 1927, and that death occurred, on the date stated above, at 2 40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

131 (duration) ..... yrs. 18 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 129 a (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? Urinalysis

(Signed) Edwin J. Kroblich, M. D

10/6, 1927 (Address) 2806 No. 12th

*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: Bellefontaine

DATE OF BURIAL: Oct 7 1927

20. UNDERTAKER: Hy Leidner Und Co

ADDRESS 1417 N. Market St.

Schedule