

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

Do not use this space.

31888

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
1003
Primary Registration District No. **City Hospital # 2**

File No.
Registered No. **9250**
St. Ward)

2. FULL NAME

Emily Cooper Hortell

(a) Residence. No. **2301 West** St. **21** 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 | *Col* | *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 20 1894*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<i>33</i>	<i>8</i>	<i>20</i>	<i>0</i>

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) *St. Louis Mo.*
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Emily Hortell*

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

14. INFORMANT *Alice Long*
(Address) *6219 Suburban Ave*

FILED *18* 19*27* *Maud Starosoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-10-1927*

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at *1:30 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Poisoning
Suicide
CONTRIBUTORY (SECONDARY)
166

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH?

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

10 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Alice Long*, M. D.

*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 *Washington Park* DATE OF BURIAL *10-18-1927*

20. UNDERTAKER *Peoples and Co* ADDRESS *3109 Franklin*

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.

