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

Do not use this space.

35577

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St. Louis (No. City Hospital St. ..... Ward)

File No. .....

Registered No. 10764

2. FULL NAME Mabel Hunsman

(a) Residence. No. 2733 Wyoming St. 24 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 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 15 - 1904

7. AGE: Years 23 Months 2 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shoe factory
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Perry Co.
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Sylvester Shaw.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) England.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Florence Risley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Hospital Information
(Address) Chowan City Hospital

15. FILED DEC -1 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 29 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1927 to Nov 29, 1927 that I last saw h. Nov alive on Nov 29, 1927, and that death occurred, on the date stated above, at 9.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia

108

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 101 A

(duration) ..... yrs. ..... mos. ..... ds.

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

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Edmund R. Sheridan M. D

11/29, 1927 (Address) City Hospital

*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: Oak Grove Cemetery
DATE OF BURIAL: Dec 2 1927

20. UNDERTAKER: A. H. McLaughlin
ADDRESS: 1631 Mo. Av.

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.

Hunlman