

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

Do not use this space.

38171

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.

Registered No. **10799**

St. Ward)

2. FULL NAME

(a) Residence. No. **1373 27** St., **2nd** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **6 1/2** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **DEC 1 1927**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Albert F Brown**

17. I HEREBY CERTIFY That I attended deceased from **Dec 26 1927** to **Dec 27 1927** that I last saw him alive on **Dec 1 1927** and that death occurred, on the date stated above, at **3:30 p.m.**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 26 - 1870**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	56	11	5	

Syphilis
Syphitic meningitis
3 1/2
930 (duration) yrs. mos. ds.

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

5010 **Chronic myocarditis**
(SECONDARY) (duration) yrs. mos. ds.

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

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

10. NAME OF FATHER **Wm Burns**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Calvary**

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

20. UNDERTAKER **Arthur J Donnelly**

12. MAIDEN NAME OF MOTHER **Anna Lee**

19. DATE OF BURIAL **12-5 1927**

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

*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.

14. INFORMANT **Chesley**
(Address) **City Hospital**

15. FILED **DEC -2 1927** **Maub Starkloff**
REGISTRAR

19. DATE OF BURIAL **12-5 1927**

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

Amn