

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

Do not use this space.

38638

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

(No. **Celestine**)

File No.

Registered No. **11324**

St.

Ward)

2. FULL NAME

(a) Residence. No. **1028 Rutger** St. **23** Ward.

Length of residence in city or town where death occurred **29** yrs. mos. da.

(If nonresident give city or town and State)

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 (write the word)

Married

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

Charles Nash

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

June 27-1880

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>47</i>	<i>5</i>	<i>20</i>	

8. OCCUPATION OF DECEASED

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

Housewife

(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)

Indiana

10. NAME OF FATHER

John Logan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana

12. MAIDEN NAME OF MOTHER

Margaret Meyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana

14.

INFORMANT (Address)

John Logan Celestine

15.

FILED **DEC 19, 1927**

Maule Starkeoff

REGISTERED

MEDICAL CERTIFICATE OF DEATH

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

Dec 17 1927

I HEREBY CERTIFY That I attended deceased from *Dec 15 1927* to *Dec 17 1927* that I last saw him alive on *Dec 17 1927* and that death occurred, on the date stated above, at *4:40 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Nephritis
34
131*

CONTRIBUTORY (SECONDARY)

Central nervous system (duration) yrs. mos. da.

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

101 (Signed) J. Starkeoff M. D. 18, 1927 (Address) Celestine

*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

New St. Marcus Cem

12-20 1927

20. UNDERTAKER

ADDRESS

Witt Bros & Co. 2929 Jefferson

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.

Nash