

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

15343

15076

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.....

City St. Louis (No. 719 Carroll)

File No.....

Registered No. 4276

St.....

Ward.....

2. FULL NAME

Mary Chabdarat

(a) Residence. No. 719 Carroll St., 230 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. da. 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)

Single

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

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

Apr. 12 - 28

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

6

8. OCCUPATION OF DECEASED

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

none

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

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Nick Chabdarat

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Serbia

12. MAIDEN NAME OF MOTHER

Sylvia Petrovich

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Serbia

14.

INFORMANT

(Address)

Nick Chabdarat
719 Carroll St.

15.

FILED

AP 19 1928

May C. Stebbins

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 18 19 28

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..... 6 P..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Malnutrition 159

CONTRIBUTORY (SECONDARY)

Premature Birth

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

19..... (Address).....

*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

Mt Hope

4-19 1928

20. UNDERTAKER

ADDRESS

W-C. Moydell

1926 Allen

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.

