

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

Do not use this space.

15666 15397

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. 4627 Natural Bridge)

File No.

Registered No. 4628

St. Ward)

2. FULL NAME ELIZABETH FARNEN

(a) Residence, No. 4627 Natural Bridge St. 7 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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (*write the word*) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 17-1866

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, ... hrs. or ... min.**
61 5 9

B. 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) Ohio
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Peter Kirk

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

12. MAIDEN NAME OF MOTHER Petelub Curude

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

14. INFORMANT Thos. H. Farnen
(Address) 4627 Nat Bridge

15. FILED APR 28 1928 Wm. C. Starnes REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 26 1928

17. HEREBY CERTIFY That I certify deceased from March 10, 1928, to April 26, 1928 that I last saw her alive on April 26 1928, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral regurgitation
Chronic mitral regurgitation

CONTRIBUTOR (SECONDARY) 129A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) F. M. Purck M. D.

(Address) 2900 Mon St

*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 Copray Cemetery **DATE OF BURIAL** 4/30 1928

20. UMBERTAKER Stook Carrol **ADDRESS** Nat Bridge

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.

