

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **100**

St. Louis, Mo. (No. *918 Lynch St.*)

File No. **18567**
Registered No. **4930**
St. _____ Ward _____

2. FULL NAME

Caroline Bequette
(a) Residence, No. *918 Lynch St.* St. *23* 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. 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 22 - 1879*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>48</i>	<i>6</i>	<i>13</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *House Wife*
(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) *Iowa*

10. NAME OF FATHER *Charles Venator*

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

12. MAIDEN NAME OF MOTHER *Ellen Miller*

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

14. INFORMANT *Carl Bequette*
(Address) *918 Lynch St.*

15. FILED *MAY -6 1928* *Max C. Starling* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 5 - 1928*

17. I HEREBY CERTIFY, That I attended deceased from *May 22 1927*, to *May 4 1928*, that I last saw her alive on *May 4 1928*, and that death occurred, on the date stated above, at *9:15 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myelogenous Leukemia

728 650
(duration) *2* yrs. - mos. - ds.

CONTRIBUTORY (SECONDARY)
(duration) - yrs. - mos. - ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *L. M. Call* *Thompson*, M. D.
75, 1928 (Address) *1808 Kirkwood 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 *St. Matthews* DATE OF BURIAL *May 8 - 1928*

20. UNDERTAKER *Ziegenhein Box 2623 Chesapeake* ADDRESS

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.

