

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

Do not use this space.

22373

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No.....)

File No.....

Registered No.....

St.....

Ward.....

2. FULL NAME

(a) Residence. No..... St..... Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 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 of (or) WIFE OF Charles Warren

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 9 - 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 56 9 11

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Memphis (STATE OR COUNTRY)

10. NAME OF FATHER Charles Drury

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Charles Warren (Address) City 1000 1st St

15. FILED 22 1923 May 2 Stark

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1928

17. I HEREBY CERTIFY That I attended deceased from June 20 1928 to June 20 1928 that I last saw him alive on June 20 1928 and that death occurred, on the date stated above, at 8:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
46 46
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of the
ovary uteri (duration) yrs. mos. ds.

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) Dr. M. A. H. H. H. M. D.
(Address) City 1000 1st 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 Calvary Cem

DATE OF BURIAL 2/23 1928

20. UNDERTAKER W. A. Stock

ADDRESS 2117 E Grand

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.

Wassan