

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

Do not use this space.

28714

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo (No. 1541 + S. 7th St)
 Registered No. 8176 St. _____ Ward)

2. FULL NAME

(a) Residence. No. 1541^A S. 7th 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 OF (OR) WIFE OF Frank Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 9 - 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 | | | |

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) Ply. Mo. and Ill.
 (STATE OR COUNTRY) Illinois

10. NAME OF FATHER William Cox

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Frank Martin
 (Address) 1541^A S. 7th St.

15. AUG 11 1925 FILED E. J. Schmur REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 9 1925

17. I HEREBY CERTIFY, That I attended deceased from Aug 7th 1925, to Aug 9th 1925 that I last saw her alive on Aug 9th, 1925, and that death occurred, on the date stated above, at 8:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute Nephritis + myocarditis
1541^A S. 7th St.
 (duration) yrs. mos. ds.
 CONTRIBUTORY Rheumatic Labronc
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: 1541^A S. 7th St

19. DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? Thyroidal findings
 (Signed) Frank J. Schmur, M. D.
8/10, 1925 (Address) 4430 Rieder 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 Cem. DATE OF BURIAL Aug 11 1925

20. UNDERTAKER E. J. Schmur ADDRESS 3125 Lafayette

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

ALL INFORMATION REQUESTED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City..... (No. St. Ward)

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 8179
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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Q</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
	If LESS than 1 day, hrs. or min.	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15. FILED OCT 10 1923 Mayb Stars-off
19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1923

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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

..... (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)....., M. D.

, 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

19

20. UNDERTAKER

ADDRESS

REGISTRATION FEE, SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

H168E-S