

**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..... County Registration District No. **1003** File No. **28832**
 City **St Louis 240** (No. **St Louis Maternity Hospital**) Registered No. **8334** (Ward)

2. FULL NAME

Denny (Mable) Maple
 (a) Residence. No. **910 St Louis and 76** Ward. (If nonresident give city or town and State)
 (Usual place of abode)

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 **married**
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 5 1898**

7. AGE YEARS MONTHS DAYS LESS than 1 day, hrs. or min.
30 **7** **19**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House**
 (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) **St Louis Mo**

10. NAME OF FATHER **J B Smith**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **St Louis Mo**

12. MARRIEN NAME OF MOTHER **Maple**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **St Louis Mo**

14. INFORMANT (Address) **910 St Louis and 76**

15. FILED 19 **Mar 21 1928** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8/24 1928**

17. I HEREBY CERTIFY, That I attended deceased from **July 26**, 19**28**, to **Aug 14**, 19**28** that I last saw her alive on **8/14**, 19**28** and that death occurred, on the date stated above, at **4:45 p m**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock from hemorrhage
12/21/28
10.5 hrs (duration) yrs. mos. da.
 CONTRIBUTORY **Rupture of uterus**
 (SECONDARY) **Hemorrhage - Postpartum**
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

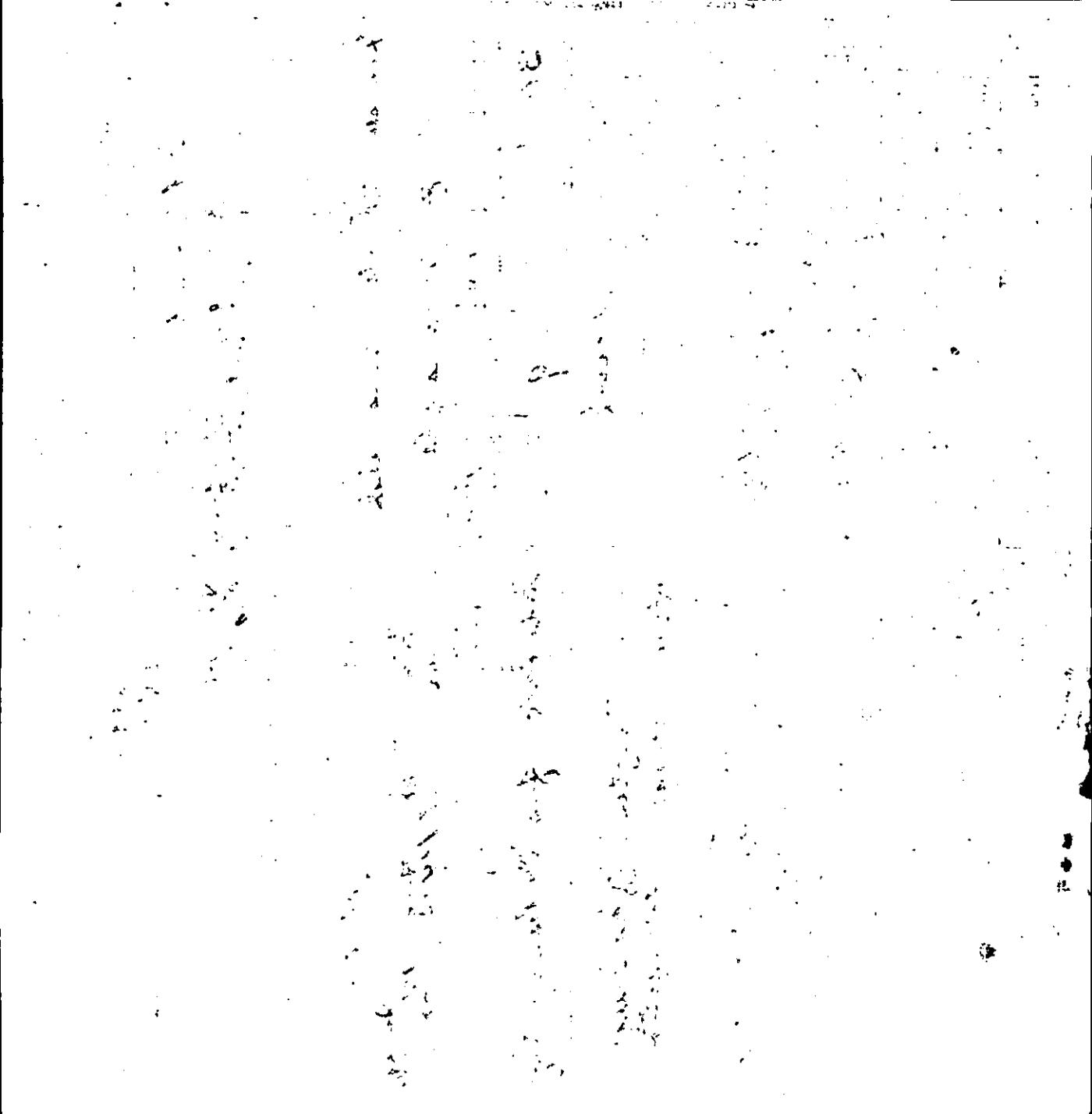
DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **8/14/28**
 WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Routine**
 (Signed) **Jesse B O'Neil** M. D.
 , 19 (Address) **630 Sotters highway**

*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**

Joseph Mo Maple **1928**
20. UNDERTAKER **ADDRESS**
J. J. Quinn **1322 Grand**



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ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

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

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 8334

2. FULL NAME

Denney Maple

(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>M</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		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-14 1928

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:

Shock from hemorrhage
Postural, information given
over phone by Dr. J. O. Keell
Div. of H.S. 10-9-28
CONTRIBUTORY (SECONDARY) Capture of uterus
hemorrhage - Distention

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.

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

15. FILED NOV 10 1928 maule Starrsloff REGISTRAR

SUPPLEMENTARY

S-28832