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

Do not use this space.
32291

1. PLACE OF DEATH

County..... Registration District No. 781
Township..... Primary Registration District No. 1003
City St. Louis, Mo. (No. ....., Sanitarium St. ..... Ward)

File No. 9605
Registered No. .....

2. FULL NAME Rose Gravelle

(a) Residence. No. 5556 W. Florissant Av. 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 4 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 17, 1896

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Missouri

14. INFORMANT W. R. Sommness
(Address) 5300 Arsenal

15. FILED SEP 29 1928 Henry C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-27 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug. 25th, 1928, to Sept. 27th, 1928, that I last saw her alive on Sept. 27th, 1928, and that death occurred, on the date stated above, at 1 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of the Insane
(duration) ..... yrs. 1 mos. 3 ds. +

CONTRIBUTORY (SECONDARY) Syphilis
(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) W. R. Sommness, M. D
, 19 (Address) 5300 Arsenal

*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: Caseyville Ills.
DATE OF BURIAL: Sept. 29 1928

20. UNDERTAKER: Ky Leidner Und Co.
ADDRESS 1417 N. Market St.

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.

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD