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

Do not use this space.

35152

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. City Hospital ..... St. ..... Ward)

File No. 10134

Registered No. .....

2. FULL NAME Josephine Arter

(a) Residence. No. 9798 (Usual place of abode) St. 15339 Patterson Ward. 13

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 - 1882

7. AGE: Years 46 | Months 4 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

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) (STATE OR COUNTRY): Italy

PARENTS

10. NAME OF FATHER: Joseph Bonigha

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

12. MAIDEN NAME OF MOTHER: unk

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

14. INFORMANT: Hospital Records

(Address): City Hospital

15. FILED Oct 15, 1928 Mae E Starkloff, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH*

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1928, to Oct 13, 1928, that I last saw h. alive on Oct 13, 1928, and that death occurred, on the date stated above, at 3:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

A. [illegible] (duration) yrs. mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Edward Welbring M.D.

10/14, 1928 (Address) City Hospital

*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 Peter & Paul

DATE OF BURIAL: Oct 16 1928

20. UNDERTAKER: Paul C Calantera

ADDRESS: 1921 Cooper

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 INK. DO NOT FOLD. USE PENCIL ONLY IF INK IS NOT AVAILABLE.

Pocket