

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

Do not use this space.

38007

**1. PLACE OF DEATH**

County St. Louis Registration District No. 783  
Township Suburb Primary Registration District No. 6074  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 103  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Laura Valle  
(a) Residence. No. Coffman 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 66 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** Col. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widow  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb 28 1860

**7. AGE**  
YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
68. 79. 7/8

**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work Nurse w/office  
(b) General nature of industry, business, or establishment in which employed (or employer) Home work  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Coffman Mo

PARENTS

**10. NAME OF FATHER** Sam Slater

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

**12. MAIDEN NAME OF MOTHER** Scherlata Slater

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

**14. INFORMANT (Address)** Luther Valle  
Farmington Mo.

**15. FILED** \_\_\_\_\_ **19** \_\_\_\_\_  
REGISTRAR

**4 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Nov 29- 1928

**17. I HEREBY CERTIFY** That I attended deceased from Nov 20, 1928, to Nov 29, 1928, that I last saw him alive on Nov 27, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Myocarditis  
Chronic degenerative life before  
930  
1100  
**CONTRIBUTORY (SECONDARY)** level Pleurisy & emphysema  
(duration) \_\_\_\_\_ yrs. mos. ds.

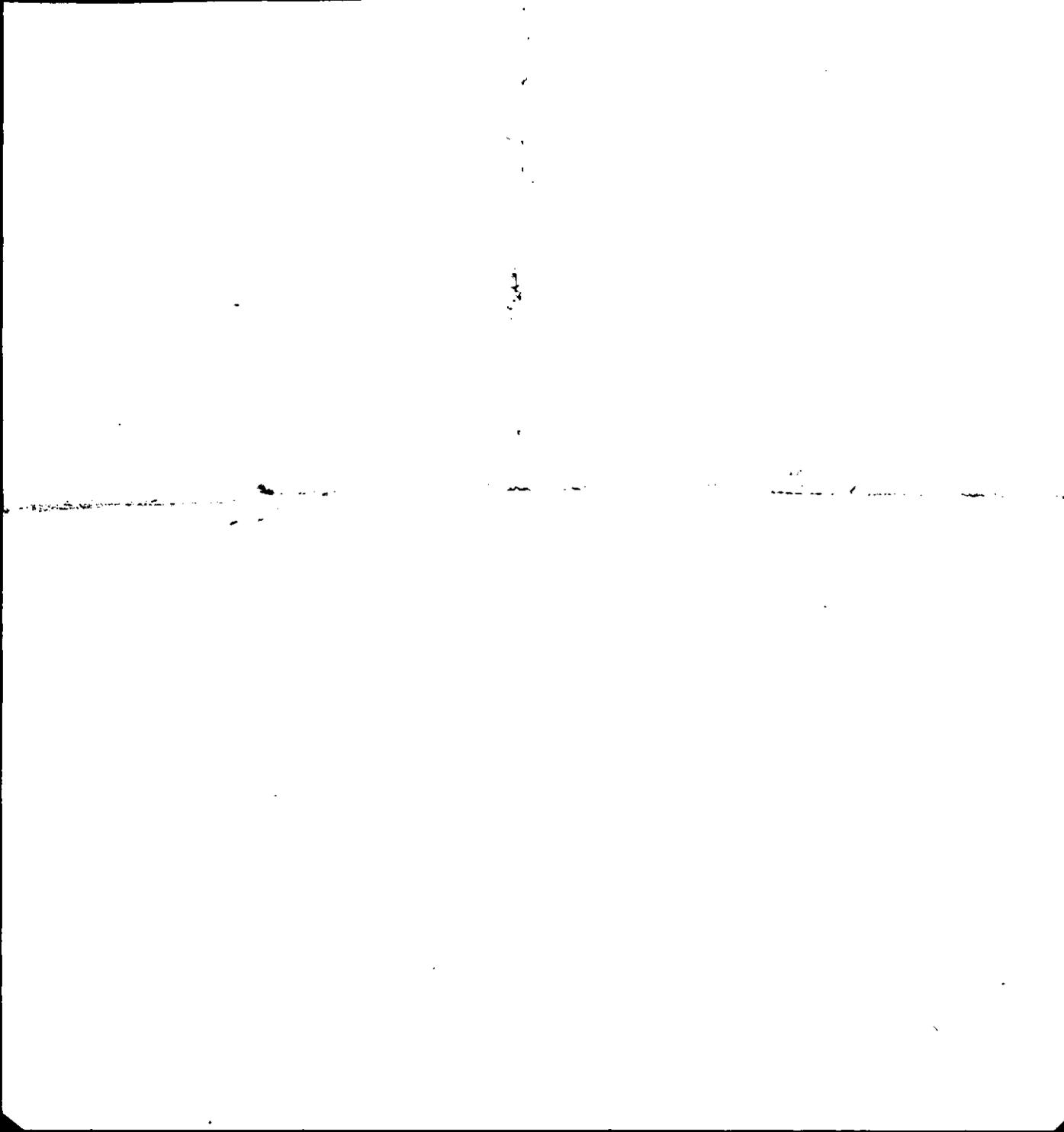
**18. WHERE WAS DISEASE CONTRACTED** Home  
**19. DID AN OPERATION PRECEDE DEATH?** No. DATE OF \_\_\_\_\_  
**20. WAS THERE AN AUTOPSY?** No.

**WHAT TEST CONFIRMED DIAGNOSIS?** Clinical  
(Signed) R. Apperson, M. D.  
(Address) Farmington Mo

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Coffman Cemetery **DATE OF BURIAL** Dec 2 1928

**20. UNDERTAKER** Fairgrove Co. Fairgrove Mo  
**ADDRESS** \_\_\_\_\_



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ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County St. Genevieve Registration District No. 283 File No. ....  
 Township Saline Primary Registration District No. 6029 Registered No. ....  
 City ..... (No. ....) St. .... Ward)

2. FULL NAME Laura Valle  
 (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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wed

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)

PARENTS

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 11/30 28 C. A. Boyd Deputy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 29 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19....., 19..... that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

S-38007