

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

Do not use this space.

38174

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *5777 Lindell Blvd.*)

File No.
Registered No. *10750*
St. Ward)

2. FULL NAME

(a) Residence. No. *5777 Lindell Blvd.* 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) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF *James P. Litton*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 19 1852*

7. AGE YEARS MONTHS DAYS *76 5 22* (LESS than 1 day, hrs. or min.)

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

9. BIRTHPLACE (CITY OR TOWN) *Cincinnati* (STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Wm. Brooke*

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

12. MAIDEN NAME OF MOTHER *Marian*

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

14. INFORMANT *Harry Crustock* (Address) *5777 Lindell Blvd.*

15. FILED *1022* *May 20 1928* Registrar

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 19 1928*

17. I HEREBY CERTIFY That I attended deceased from *Nov 20 1928* to *Nov 20 1928* that I last saw h. *ex.* alive on *Oct 31 1928*, and that death occurred, on the date stated above, at *6:20 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

50 *General arteriosclerosis*
of the *coronary*
arteries
of the *heart*
of the *heart*
(duration) *2* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Diabetes Mellitus*
(duration) *4* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *at home* IF NOT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WHAT TEST CONFIRMED DIAGNOSIS *Others not* (Signed) *Rephome M. Chisholm, M.D.* (Address) *20 West 11th 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 DATE OF BURIAL

Bellefontaine *11/3 1928*

20. UNDERTAKER *Wagon* ADDRESS *3671 Olive*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
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.

