

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

Do not use this space.

43191

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **4437** **Kennedy**)

File No.
 Registered No. **12187**
 St. Ward)

2. FULL NAME

(a) Residence. No. **4437 Kennedy** St., **11** Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **45** 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 (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known - 1872**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 56 — — —

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

9. BIRTHPLACE (CITY OR TOWN) **Not known**
 (STATE OR COUNTRY) **Miss.**

10. NAME OF FATHER **J. Huaton**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Not known**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER " "

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

14. INFORMANT **Wm Bradshaw**
 (Address) **4437 Kennedy**

15. FILED **21 1924** **Wm C. Starnes** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 17** 19**24**

17. I HEREBY CERTIFY That I attended deceased from **Dec 15** 19**24** to **Dec 17** 19**24**
 that I last saw **er** alive on **Dec 17** 19**24**, and that death occurred, on the date stated above, at **11:15** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: **MI**
MI (duration) yrs. **3** mos. **26** ds.
 CONTRIBUTORY **cardiac asthma** (SECONDARY)
non Tuberculosis (duration) yrs. **3** mos. **ds.**

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

19. DID AN OPERATION PRECEDE DEATH **no** DATE OF.....

20. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Chloroform**
 (Signed) **Vincent J. Mueller, M.D.**
XII-17-1924 (Address) **2235 Franklin**

*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 **Greenwood Cemetery** DATE OF BURIAL **12/24/24**

20. UNDERTAKER **J. Williams** ADDRESS **3232 Pine**

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

R. E.—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.

