

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

Do not use this space.

43247

1. PLACE OF DEATH

County..... Registration District No. 791 File No.
 Township St. Louis No. 5515 Menassa Cr. Primary Registration District No. 1003 Registered No. 12554
 City (No. St. Ward)

2. FULL NAME

(a) Residence. No. 5515 Menassa Cr. St. 6 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 or (OR) WIFE OF Alma Naustin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 6, 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 8 | 15

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) Manchester
 (STATE OR COUNTRY) England

10. NAME OF FATHER Mrs. Wilson

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

12. MAIDEN NAME OF MOTHER Alma Whitehead

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

14. INFORMANT Alma Naustin
 (Address) 5515 Menassa Cr.

15. FILED DEC 23 1928 Max C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 1928

17. I HEREBY CERTIFY That I attended deceased from Dec 16, 1928 to Dec 21, 1928, and that I last saw him alive on Dec 21, 1928, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Polar Pneumonia
2. Chronic Myocarditis
 CONTRIBUTORY (SECONDARY) Chronic Myocarditis
 (duration) 3 yrs. 2 mos. 1 da.

18. WHERE WAS DISEASE CONTRACTED 10/10
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) Wm. Greener D
 , 19 (Address) 5435 Eastern

*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 Bellevue Cemetery DATE OF BURIAL 12/24/28

20. UNDERTAKER Bergend Co. 3661 Washington St. ADDRESS

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.

