

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

Do not use this space.

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44

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City *St. Louis Mo.* (No. *3717*) *Ludlow St.*.....St. ....Ward)

File No. ....  
 Registered No. **76**

**2. FULL NAME**

*Winnifred Margaret Stroop Sproot*  
 (a) Residence. No. *3717 Ludlow St.*.....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 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) *Sept. 12, 1866*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .... hrs. or .... min.	
				<i>62</i>	<i>3</i>

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) *Washington Mo.*

10. NAME OF FATHER *Antoine Pollite*

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

12. MAIDEN NAME OF MOTHER *Myrtle Jones*

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

14. INFORMANT (Address) *Chas. Gray 1102 Lutter Ave*

15. FILED *2* 19*29* *Max C. Stark* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-31-1928*

17. I HEREBY CERTIFY That I attended deceased from *DEC 9 - 1928* to *DEC 31 1928*  
 that I last saw *her* alive on *DEC 31 1928*, and that death occurred, on the date stated above, at *8:40 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*46B*  
*100*

*LOBAR (RT Side)*  
*Pneumonia* (duration) yrs. mos. *5* ds.

CONTRIBUTORY *Carcinoma of Stomach* (SECONDARY) (duration) *6* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *444 W*  
 (CITY OR TOWN) (STATE OR COUNTRY) (IF NOT AT PLACE OF DEATH) *—*

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

WHAT TEST CONFIRMED DIAGNOSIS *Phys Exam*  
 (Signed) *Dr. Francis J. Keller, M.D.*  
 , 19 (Address) *Miss Club Bldg.*

\*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's Cemetery* DATE OF BURIAL *3-1929*

20. UNDERTAKER *J. J. Quinn* ADDRESS *1004 Grand*

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.

