

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

Do not use this space.

43654-8092

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.....

Registered No. **535**

St. .... Ward

**2. FULL NAME**

(a) Residence. No. **1500<sup>th</sup> Pine** St., **25** 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

**Female White Single**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 26 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 25**, 19**28**, to **Dec 26**, 19**28**, that I last saw him alive on **Dec 25**, 19**28**, and that death occurred, on the date stated above, at **1:15 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Lobar Pneumonia, meningitis due to the pneumococcus**

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

**24**

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

**Waitress**

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical Organisms in**

(Signed) **Edward Shelving, M. D.**

**26**, 19**28** (Address) **City Hospital**

\*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.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

**Tennessee**

10. NAME OF FATHER

**unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

**unknown**

12. MAIDEN NAME OF MOTHER

**unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

**unknown**

14. INFORMANT

(Address)

**City Hospital**

15. FILED

**JAN 1 1929**

**Max C. H. H. H.**

REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

**St. Matthew Cemetery Jan 11 1929**

20. UNDERTAKER

ADDRESS

**E. G. Schmor 3125 Lafayette Ave.**

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.

Gardner