

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

Do not use this space.

3385

1. PLACE OF DEATH

County St. Louis
Township Central
City Edgewood

Registration District No. 789
Primary Registration District No. 6033 B
(No. 4816)

File No. _____
Registered No. 9
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Cahokia Hill Ward. Cahokia Hill
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. _____ da. _____
How long in U.S., if of foreign birth? yrs. _____ mos. _____ da. _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1929

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edward Cordovan

I HEREBY CERTIFY That I attended deceased from Jan 3 1929 to Jan 5 1929 that I last saw her alive on Jan 16 1929 and that death occurred on the date stated above on Jan 5 1929 at 10 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29 1855

THE CAUSE OF DEATH* IS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 4 16 17

Fever Pneumonia

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 _____

CONTRIBUTORY (SECONDARY) Diabetes Mellitus

9. BIRTHPLACE (CITY OR TOWN) Florissant (STATE OR COUNTRY) Mo

18. WHERE WAS DISEASE CONTRACTED Mo IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER Frank Montine

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo

WAS THERE AN AUTOPSY No

12. MAIDEN NAME OF MOTHER Unknown

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Wm. H. Houchens M.D. (Address) 3601 Center St. W.

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

*State the DISEASE CAUSING DEATH, if medical, and HISTORY CAUSING DEATH (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

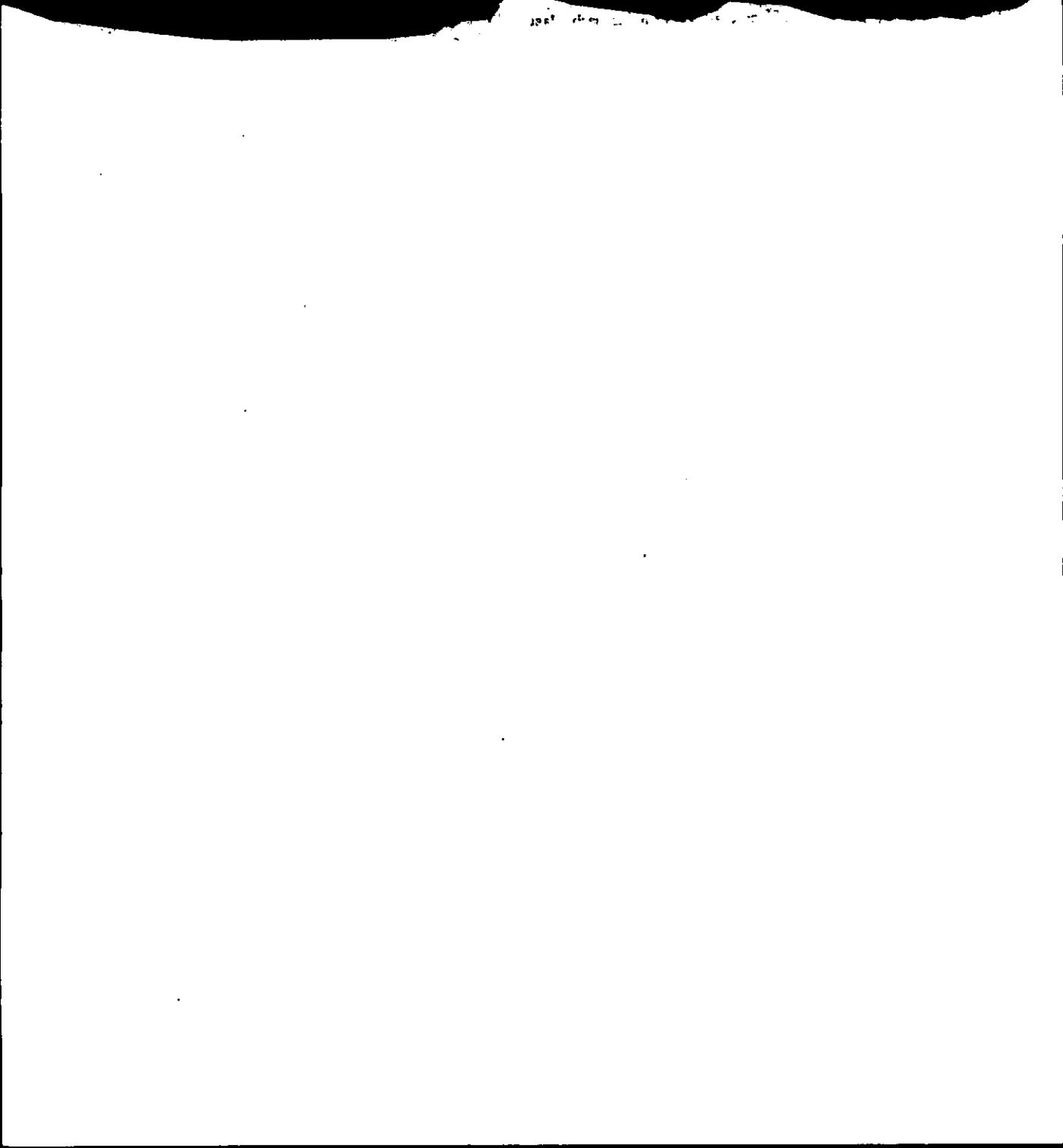
14. INFORMANT Alvina Faulds (Address) 4816 Edgewood

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cahokia Hill DATE OF BURIAL 1-8-1929

15. FILED 1/7 1929 Pella Gray N.J. REGISTRAR

20. UNDERTAKER Brisler Bros ADDRESS Coast St. Cahokia Hill

City and county classified



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 989 File No.
 Township Central Primary Registration District No. 6033B Registered No. 7
 City (No.) St. Ward (If nonresident give city or town and State)

2. FULL NAME Zilda Condavant
 (a) Residence No. St. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 - 1853

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>73</u>	<u>4</u>	<u>15</u>	

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5 - 1929

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

*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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 1/7 19 29 Polla Gray, M.D. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS

20. UNDERTAKER ADDRESS

Every item of information should be carefully reported. 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33385