

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

Do not use this space.

3708

**1. PLACE OF DEATH**

County.....

Registration District No. 791

File No. ....

Township.....

Primary Registration District No. 1003

Registered No. 308

City.....

5311 Northland

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 5311 Northland 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. 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) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. L. Girard (P.)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 15 1876

7. AGE YEARS MONTHS DAYS 52 9 20 H LESS than I day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, 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) Sveveden

10. NAME OF FATHER Unknown Peterson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. Informant (Address) Mrs. E. R. Mayr  
5311 Northland

15. FILE NO. 14N-7-1020 REGISTRATION

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Oct 1928, to Jan 5th 1929 (that I last saw live on Jan 2nd 1929, and that death occurred, on the date stated above, at 11:50 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: Pulmonary tuberculosis  
23A

Probably several (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None known (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 31 IF NOT AT PLACE OF DEATH: .....

0 Did an operation precede death? no DATE OF .....

Was there an autopsy? no

WHAS TEST CONFIRMED DIAGNOSIS? Spitting Exam at City Hospital  
(Signed) J. M. Sullivan, M. D.  
, 19 (Address) 3801 Lee Ave

\*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 Cabary DATE OF BURIAL Jan 8 1929

20. UNDERTAKER Beurich-Neubauer ADDRESS 1138 N. 6

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.

THIS IS A PERMANENT RECORD

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24  
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Dr W. D. Lyell  
3801 Lee