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.

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

Do not use this space.

4550

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1234

City St. Louis (No. 3503 9 Giles ave St. ..... Ward)

2. FULL NAME Lillie Hale

(a) Residence. No. 3503 9 Giles ave St. 16 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18 - 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	11	6	

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) Ills

PARENTS

10. NAME OF FATHER a. H. Johns

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT James Hale
(Address) 3503 9 Giles ave

15. JAN 25 1929 Max C. Starkloff
FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 24, 1929

17. I HEREBY CERTIFY, That I attended deceased from 12/21, 1929, to 1/24, 1929, that I last saw her alive on 1/24/29, 19....., and that death occurred, on the date stated above, at 7 15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Myocarditis Chr. - 12 930

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Nephritis Chr. -

..... (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1290

IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Urine test X-Ray of chest.

(Signed) Ebert Simpson, M. D

Washington 1921 (Address) 3729 Gravois 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	DATE OF BURIAL
New St. Marcus	Jan. 26 1929
20. UNDERTAKER	**ADDRESS**
Wacker-Helderle	2331 So. Bing