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

Do not use this space.

4840

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 1534

City St Louis (No. St Louis Baptist Hosp St. ..... Ward)

2. FULL NAME Isabelle Metz

(a) Residence. No. 4022 Penrose St., 110 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: David S Metz

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sep. 14 - 1857

7. AGE: Years 71 Months 4 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(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): Mo

PARENTS

10. NAME OF FATHER: Joseph Beard
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): England
12. MAIDEN NAME OF MOTHER: Ann Hardin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): England

14. INFORMANT: Amelia Peterson
(Address) 4022 Penrose St

15. FILED -1 1929 Max C Tarkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 31 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan ~~30~~ 29, 1929, to Jan 31, 1929 that I last saw her alive on Jan 30, 1929, and that death occurred, on the date stated above, at 1.30 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

120 Complete
Abstinction of Bowels
from eating
Boon & Chicken Croquet (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Stomach & Bowel Disorder (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? St Louis Baptist Hospital

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) D M F Hermann, M. D

2/1, 1929 (Address) 2743 N Grand

*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: Bellefontaine
DATE OF BURIAL: Feb 2 1929

20. UNDERTAKER: Alaon L U Co
ADDRESS: 2707 N Grand

235
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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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD