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

Do not use this space.

4848

1. PLACE OF DEATH

County..... Registration District No. 701

Township..... Primary Registration District No. 1002

City..... (No. Barnes Hosp. St. ..... Ward)

File No.....

Registered No. 1543

2. FULL NAME Lucy Mable Kalb

(a) Residence. (Usual place of abode) No. 4366 Swan St., [redacted] Ward 18 (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: White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 20-1888

7. AGE: Years 40 | Months 7 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): St. James (STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: J. J. Tucker

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

12. MAIDEN NAME OF MOTHER: Lavinia Owens

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

14. INFORMANT: Hermon Kalb. (Address) 4366 Swan

15. FILED FEB 1 1929 Mary C. Fulton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-31 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-22 1929, to 1-31 1929, that I last saw h. alive on 1-31 1929, and that death occurred, on the date stated above, at 4:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Uterus 48 hr. 46 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Terminal Pneumonia. Lobar (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) N. Monnaol, M. D.

, 19 (Address) 600 S. Kingshighway

*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: St. James Mo. DATE OF BURIAL: Feb. 2 1929

20. UNDERTAKER: Robt. J. Ambrister ADDRESS: 4291 N. Euclid

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.

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