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

Do not use this space.

8031

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 1677

City St Louis (No. 500 So Kingshighway St. ..... Ward)

2. FULL NAME Rose Ellen Delmaine

(a) Residence. No. 6423 Wade St., 4 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 F. | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 26 1929

7. AGE YEARS — MONTHS — DAYS 8 — If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER Elbert Delmaine

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

12. MAIDEN NAME OF MOTHER Agnes Fitzpatrick

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

14. INFORMANT Elbert Delmaine
(Address) 6423 Wade Ave

15. FILED ....., 19.. Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/3/29 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1929, to Feb 3, 1929, that I last saw her alive on Feb 2, 1929, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Failure
15 DC
..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) Failure of foramen 7
Ovale to close properly (duration) ..... yrs. ..... mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 6423 Wade
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Blue condition
(Signed) W W Simms, M. D
2/4/, 1929 (Address) 4559 Cadet

*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 Calvary Cem | DATE OF BURIAL 2/5/29 19

20. UNDERTAKER Croghan - 7146 Manchester | ADDRESS

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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