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

Do not use this space.

8581

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital St. ..... Ward)

File No. ..... Registered No. 2250

2. FULL NAME Leona Sanders

(a) Residence. No. 1822 & 13 St., 23 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 2 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 17 1903

7. AGE: Years 25 Months 11 Days 1 If LESS than 1 day, ... hrs. or ..... min.

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

2 34

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Louis Sanders

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

12. MAIDEN NAME OF MOTHER Effie Irvinary

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

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14. INFORMANT Hospital Information
(Address) E. Kirwin City Hospital

15. FILED FEB 19 1929 Wm C Stanley Jr. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 18 1929

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to Feb 18, 1929, that I last saw her alive on Feb 18, 1929, and that death occurred, on the date stated above, at 1 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Post Operative Bronchopneumonia following cholecystectomy for [illegible] (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

126 127A 107A

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) [illegible] M.D.

7/18, 1929 (Address) City Hospital

*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: Bement Ill

DATE OF BURIAL: 2-19-1929

20. UNDERTAKER: Weick Bros

ADDRESS: 220 So Grand

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.

Sanders