

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

Do not use this space.

8677

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

1008

File No.....

Township.....

Primary Registration District No.....

Registered No. **2350**

City *St. Louis*

(No. *114 Mulanphy St rear*) St. .... Ward)

**2. FULL NAME**

(a) Residence *114 Rear Mulanphy St. 26* (If nonresident give city or town and State)

Length of residence in city or town where death occurred *56* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*Female*

**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**

*William S. Norris*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*Not known 80 4*

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

*abt. 65 Unknown*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

*at home*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

*Missouri*

**10. NAME OF FATHER**

*Not known*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Unknown*

**12. MAIDEN NAME OF MOTHER**

*Millie Henderson*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Virginia*

**14. INFORMANT**

(Address)

*Mrs. Little Smith 922 Grand St.*

**15. FILED**

19 *21*

*Max W. Starker*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

*2*

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*2-17 1929*

**17.**

I HEREBY CERTIFY That I attended deceased from *Jan 1* 19*29* to *Feb 17* 19*29* that I last saw h. .... alive on *Feb 17* 19*29* and that death occurred, on the date stated above, at *St. Louis*

**THE CAUSE OF DEATH\* was as follows:**

*Chronic subacute nephritis*

**CONTRIBUTORY (SECONDARY)**

*Chronic Endocarditis*

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF *no*

WHAT TEST CONFIRMED DIAGNOSIS?

*Clinical*

(Signed) *W. C. ...* M. D. *Feb 15* 19*29* (Address) *1809 70 9 St.*

\*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

*Greenwood Cemetery 2-21 1929*

**20. UNDERTAKER**

ADDRESS

*R. M. Green 9577 Soledad*

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.

*2350*  
*1*  
*1*  
*2*

