

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

Do not use (his space).

9046

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township Alton Central Mo. Primary Registration District No. 1003 File No. 2719  
 City Alton Central Mo. St. Missouri Registered No. 2719 Ward

**2. FULL NAME**

(a) Residence. No. Rockwood Mo. ROUTE 12, Box 98, Ward 2 Alton Mo  
 (Usual place of abode) (If nonresident give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

**2 MEDICAL CERTIFICATE OF DEATH**

3.-SEX Female 4. COLOR OR RACE White 5. SINGLE MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3-1894

7. AGE Years Months Days If LESS than 1 day, hrs. or min.  
35 | 1 | 25 | — hrs. — min.

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Del. 1928 to Feb 28 1929 that I last saw her alive on Feb 28 1929 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Alumina in Esophagus  
148 (duration) yrs. mos. da. 10 da.

CONTRIBUTORY Cerebral Deterioration (SECONDARY) (duration) yrs. mos. da.

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

10. NAME OF FATHER J. McLockwood

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

12. MAIDEN NAME OF MOTHER Sarah A. Daniel (STATE OR COUNTRY)

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

14. INFORMANT Pete Loh (Address) Rockwood Mo.

15. FILED Feb 28 1929 Max C. Barker REGISTRAR

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH. Home

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2-22-29

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) W. H. Hayes, M. D.  
 (Address) 3505 W. 1st

\*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 Valhalla DATE OF BURIAL March 2 1929

20. UNDERTAKER Central ADDRESS 1841 Cass

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

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Grand Hebert