

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

Do not use this space.

12361

1. PLACE OF DEATH

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 2881
 City St. Louis (No. 5003, Kingshighway) St. _____ Ward _____

2. FULL NAME Emma Pass

(a) Residence. No. 800 Washington St. 12 Ward. _____
 (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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED ✓ (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-13-29

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 20

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Louis Pass

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

12. MAIDEN NAME OF MOTHER Mabel Jackson

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

14. INFORMANT Hudnell (Address) 5001 S Kingshighway

15. FILED 1029 1929 Mar 6 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 3-4, 1929, to 3-5, 1929, that I last saw he/she alive on 3-4, 1929, and that death occurred, on the date stated above, at 7:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebrospinal meningitis (non-epidemic)
- Streptococcus
 (duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED None
 IF NOT AT PLACE OF DEATH? None

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Examination & autopsy
 (Signed) A. C. Edwards, M.D.

3-5, 1929 (Address) 5001 S. Kingshighway

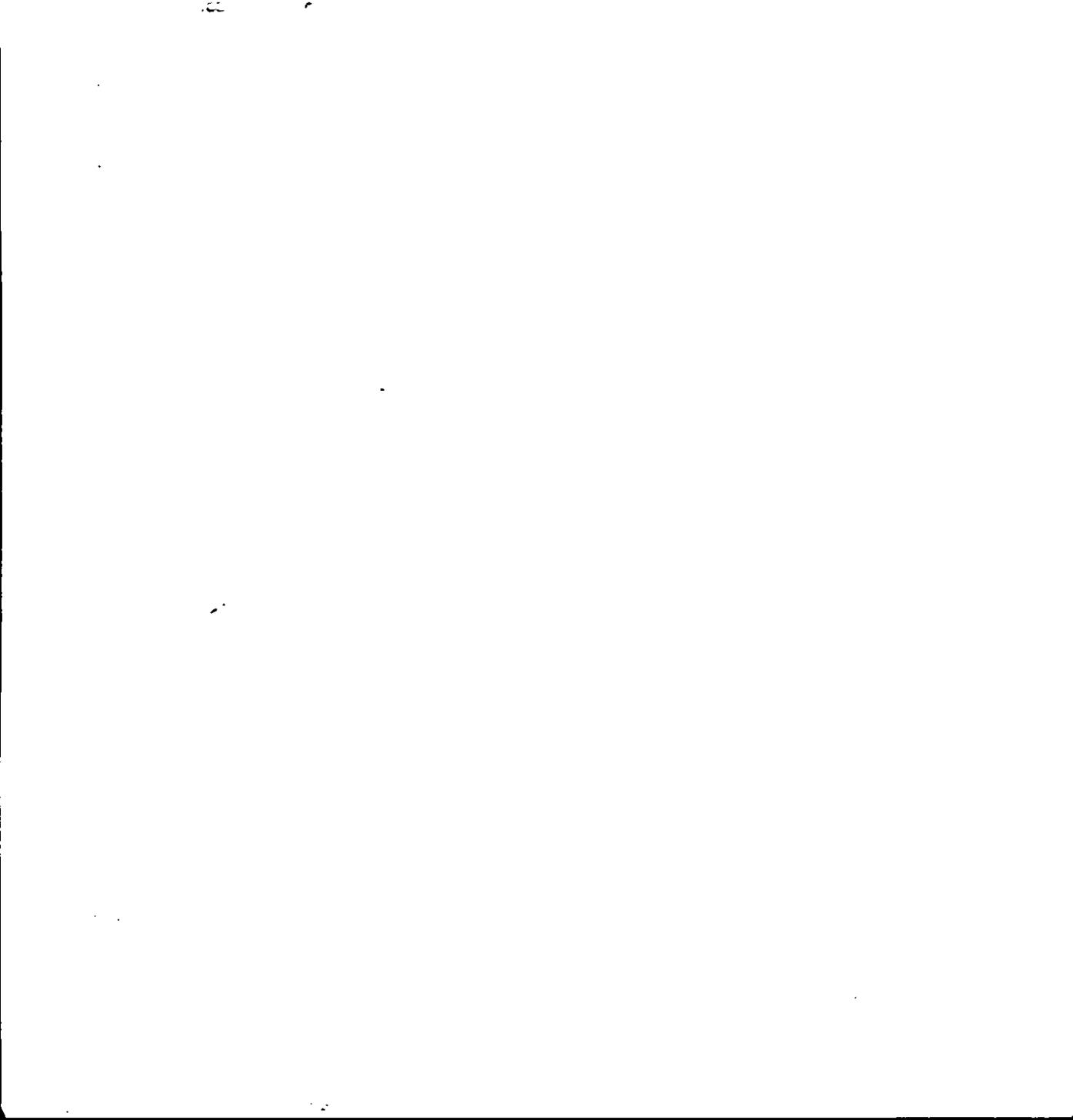
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Walhalla Cem Mar 6 1929

20. UNDERTAKER Jas. W. Clark ADDRESS 1425

Hodiamon



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 2881
 City..... (No. Childs Hosp.) St. Ward)

2. FULL NAME

Emma Pass
 (a) Residence. No. 8000 Washington Ward. St. Louis Ca
 (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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 13/29

7. AGE YEARS MONTHS DAYS 20 LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address) Max C. Storkel

15. FILED AUG - 6 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 3 1929

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... (that I last saw h. alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. da.

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

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)....., M. D.
 , 19 (Address)

*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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PREPARED BY LAW

SUPPLEMENTARY

S-12361