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

Do not use this space.
12667

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis Mo. (No. Deaconess Hospital St. ..... Ward)

File No. .....
Registered No. 3201

2. FULL NAME Lillian Hirshberg

(a) Residence. No. 4061 Cottage St., 11 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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15. 1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	8	26	

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

9. BIRTHPLACE (CITY OR TOWN) Quincy
(STATE OR COUNTRY) Indiana

PARENTS
10. NAME OF FATHER John Overall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Cecil McGill
(Address) 4061 Cottage

15. FILED ..... 19 ..... 1929 Mar 14 H23 Mr C Starbuck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 11 1929

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to March 11, 1929 that I last saw h. alive on March 11, 1929, and that death occurred, on the date stated above, at 1:10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108 / 93C / 1010
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (SECONDARY) Chronic Myocarditis
(duration) ..... yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination
(Signed) A. R. Shuffler, M. D
3/14, 1929 (Address) 1021 Mo. Bldg St Louis Mo.

*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
New St Marcus Cemetery	3-13-1929
20. UNDERTAKER	**ADDRESS**
McLaughlin	1631 Mo. ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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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