

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

Do not use this space.

16097

1. PLACE OF DEATH

County..... Registration District No. **79T**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **2519 Glasgow**)

File No.....
Registered No. **4129**
St..... Ward)

2. FULL NAME *Helena Dale*

(a) Residence. No. **2519 Glasgow** St., **70** 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 *Females* 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 *Alfred Dale*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec. 25 1868*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>61</i>	<i>3</i>	<i>11</i>	

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.....

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Not known*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT *Clarence Dale*
(Address) *2820 Glasgow*

15. FILED -7 1929 *W. C. [Signature]* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr. 6 1929*

17. I HEREBY CERTIFY, That I attended deceased from August 15, 1927, to April 6, 1929 that I last saw her alive on April 6, 1929, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia Hypostatic

CONTRIBUTORY *Hypertrophic atherosclerosis* (SECONDARY) (duration) 4 yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *at place of death*

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

WAS THERE AN AUTOPSY? *no*

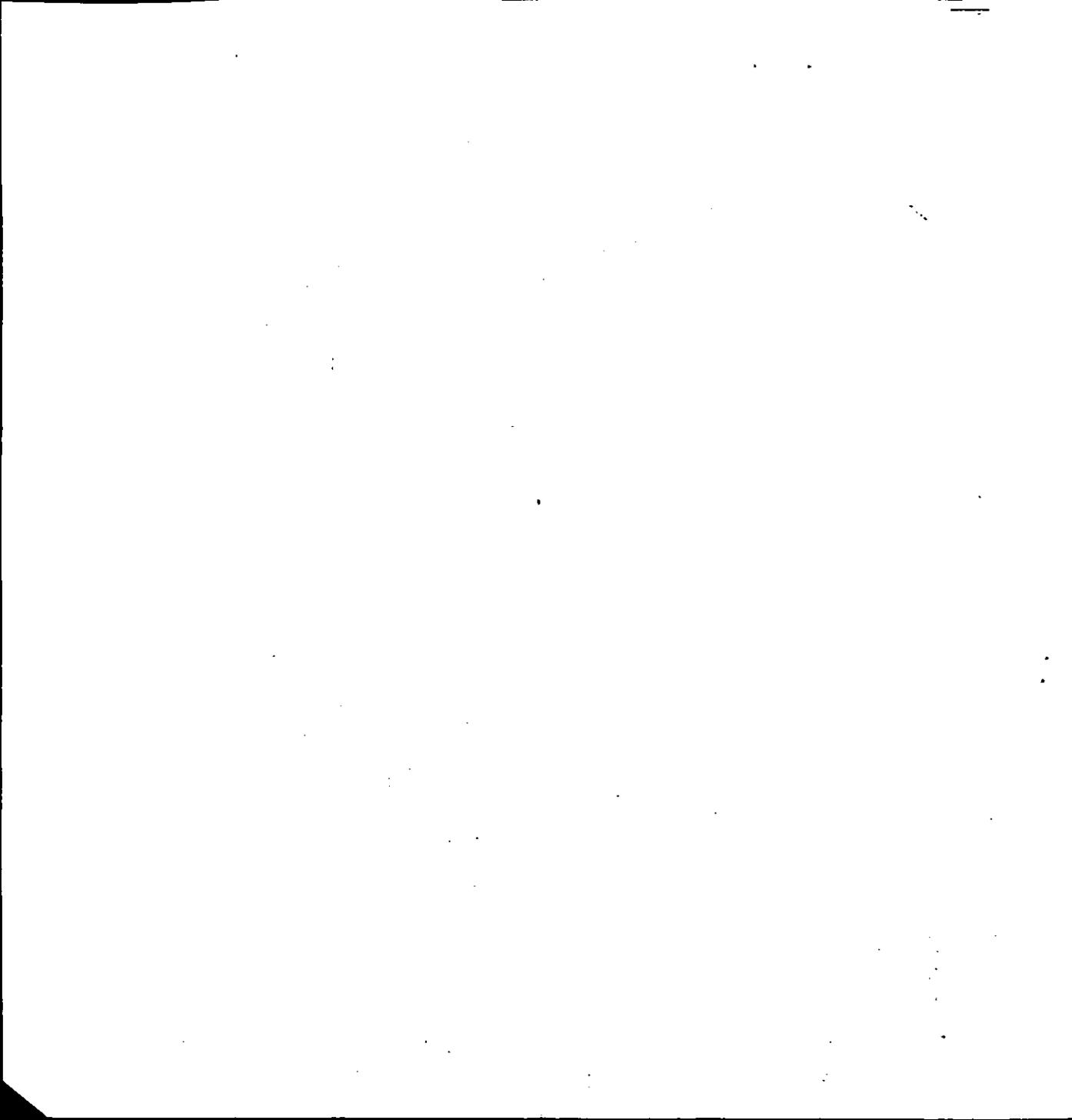
WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
(Signed) *James Lambert* M. D.
4/6, 1929 (Address) *2900 California Ave*

*State the DISEASE CAUSING DEATH, or in death 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 *Apr. 8 1929*

20. UNDERTAKER *Wm. F. Paschedag* ADDRESS *2825 No Grand St*

235-60
1929



**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 St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 4129
 City St. Louis (No. _____) St. _____ (Ward)

2. FULL NAME

Helena Dale
 (a) Residence. No. _____ St. _____ 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25-1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
X 60 3 11

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) _____
 (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) _____

15. FILED JUL - 11 - 1939 Max E. Parry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 6 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. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 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 Mr J Pascheda ADDRESS _____

SUPPLEMENTARY

5-16097

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