

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

Do not use this space.

18062
2106

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1. PLACE OF DEATH:

County Jackson Registration District No. 1002 File No. _____
 Township East Primary Registration District No. _____ Registered No. _____
 City St. Louis Mo. (No. 1002) Mercy Hosp. St. _____ Ward _____

2. FULL NAME

Mona Kitcher
 (a) Residence. No. Mendon Mo. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-9-29
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 0 27
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mendon Mo. (STATE OR COUNTRY) _____
 10. NAME OF FATHER William Kitcher
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Mona
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown (STATE OR COUNTRY) _____

14. INFORMANT Mercy Hoeph (Address) Kansas City Mo
 15. FILED 5/6 1929 M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-6 1929
 17. I HEREBY CERTIFY, That I attended deceased from 4-21-29 to 5-6-29 that I last saw him alive on 5-6-29 and that death occurred, on the date stated above, at 1:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pericarditis
119B
159 (duration) yrs. mos. ds.
 CONTRIBUTORY Gastro intestinal upset (SECONDARY) (duration) yrs. mos. ds. 4

18. WHERE WAS DISEASE CONTRACTED Home IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical Signs
 (Signed) M. Brewer M. D.
5/6 1929 (Address) Mercy Hospital
 *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 Mendon Mo. DATE OF BURIAL May 6 1929
 20. UNDERTAKER H. Newcouper's Sons ADDRESS R. B. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is vs.

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