

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

Do not use this space.

25930

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1008
 City St. Louis Mo No. 3913 Flad av. St. 17 Ward.

File No.
 Registered No. 7109
 St. Ward)

2. FULL NAME

Mary E. Hand
 (a) Residence. No. 3913 Flad av. 17 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 (use the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 2-1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 9 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wife
 (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) Missouri

10. NAME OF FATHER

Frank Chandler

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Mary Bean

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

14.

INFORMANT Mr. Arthur C. Hand
 (Address) 3913 Flad av.

15.

FILED ULL - 6 1323
 REG. Max C. Stark

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5 1929

17. HEREBY CERTIFY, That I attended deceased from 6-3 1929 to 7-5 1929 and that I last saw him alive on 7-4 1929 and that death occurred, on the date stated above, at 12:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

2
97
Endocarditis (duration) Chronic mos.
 CONTRIBUTORY Atherosclerosis (SECONDARY) (duration) Chronic yrs. mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF.....
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Physical Lab
W.H. S. M. D.

(Signed) 7/6 1929 (Address) 1800 Olive

*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

Ste. Genevieve Mo July 8 1929

20. UNDERTAKER

ADDRESS

E. J. Schmur 3125 Lafayette
av

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

2562

REGISTRAR

