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

Do not use this space.

26665 (1)

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 7941

City St. Louis, (No. 1435 Wright St. St. ..... Ward)

2. FULL NAME Leita Lerch

(a) Residence. No. 1435 Wright St. St., 26 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 17 1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	30	8	13	

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

PARENTS

10. NAME OF FATHER Hunter Lyall

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

12. MAIDEN NAME OF MOTHER Anna Vandergriff

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

14. INFORMANT August Lerch
(Address) 1435 Wright St

15. FILED AUG -1 1929 Max C. Starkloff REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 30 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1929, to July 30, 1929 that I last saw her alive on July 30, 1929, and that death occurred, on the date stated above, at 3:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis
23A
93A (duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis acute
(duration) yrs. mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Not known
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) John C Creane, M. D.
7-31, 1929 (Address) 2504 N 14th St.

*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
Valhalla Cem	Aug 1 1929
20. UNDERTAKER	ADDRESS
Theo W. Beiderwieden	1936 St. Louis

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.

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