

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

Do not use this space.

26672 *111*

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City *St. Louis, Mo.* (No. *2316*), *Franklin* *Rears* St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

*Rose Henderson*  
 (a) Residence. No. *2316 Franklin Rears* Ward. *21*  
 (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** *Colored*  
**5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (*write the word*) *Widowed*  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** *Widowed*  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *abt. 1863*  
**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*abt. 66* *unknown*  
**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) (STATE OR COUNTRY)** *Miss. -*  
**10. NAME OF FATHER** *Wm. Salty -*  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** *Miss. -*  
**12. MAIDEN NAME OF MOTHER** *Maria Rose*  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** *Miss. -*

**14. INFORMANT** *Maria Stanley*  
 (Address) *2316 Franklin Rears*  
**15. FILED** *AUG - 3 1929*  
*May C. Stahl*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *July 26 1929*  
**17. I HEREBY CERTIFY**, That I attended deceased from *May 1929* to *July 26 1929*  
 that I last saw him alive on *July 26 1929* and that death occurred, on the date stated above, at *2:30* p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Chronic Interstitial Nephritis*  
*131*  
 (duration) *1* yrs. *4* mos. ds.  
**CONTRIBUTORY (SECONDARY)** *1290*  
 (duration) yrs. 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? *no*  
 WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*  
 (Signed) *James J. Altshuler* M. D.  
 (Address) *14 Jones Ave*

\*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** *Greenwood Cemetery* DATE OF BURIAL *Aug. 3 1929*  
**20. UNDERTAKER** *W. C. Gordon and C. Morgan* ADDRESS *2649*

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.

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