

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

Do not use this space.

29079

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis Mo. (No. 1613 Blair Ave.) St. Ward)

File No.....
Registered No. 8202

2. FULL NAME

Lillian Boldridge
(a) Residence. No. 1613 Blair Ave. 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 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 30 - 1895

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,
	<u>34</u>	<u>4</u>	<u>9</u>	hrs. or

8. OCCUPATION OF DECEASED
(a) Trade, profession, or 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) Ills.
(STATE OR COUNTRY)

10. NAME OF FATHER Frederick Merkle

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

12. MAIDEN NAME OF MOTHER Elizabeth Bott

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

14. INFORMANT Grove Boldridge.
(Address) 1613 Blair Ave

15. FILED 11 19 1929
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9th 19 29

17. I HEREBY CERTIFY, That I attended deceased from August 22nd 19 29 to Aug 9th 19 29 that I last saw h. alive on Aug 9th 19 29 and that death occurred, on the date stated above, at 4:59 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY) (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 (Signed) Allen J. Roe, M. D. 8/10 1929 (Address) 2712a 7th 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 Edwardsville Ills. DATE OF BURIAL Aug 10 19 29

20. UNDERTAKER By Leidner and Co. S. Market ADDRESS 1417

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.

COPY WITH OPAFING INK---THIS IS A PERMANENT RECORD

