

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

Do not use this space.

29109

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 2003
 City St. Louis, Mo. (No. Josephine Hosp.)

File No.
 Registered No. 8581
 St. Ward)

2. FULL NAME

Nilda Coons
 (a) Residence. No. 6442 Arsenal St. St. 3 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 16 - 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
44 8 4

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. House 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) St. Louis Mo.

10. NAME OF FATHER Gus Scharringhauser

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

12. MAIDEN NAME OF MOTHER Mary Holland.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

14. INFORMANT (Address) Gus Scharringhauser
6442 Arsenal St.

15. FILED..... 19 May C. Stork REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1929 to Aug 20 1929 that I last saw him alive on Aug 20 1929, and that death occurred, on the date stated above, at 5:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Peritonitis

CONTRIBUTORY (SECONDARY) Ruptured appendix (duration) yrs. mos. 5 ds.
5 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Aug. 19-29
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Operation
 (Signed) W. Waghubach M. D.
8/21 1929. (Address) 4738 Travis 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 New St. Marcus DATE OF BURIAL 8-23-1929

20. UNDERTAKER Ziegler Bros. 2623 Lechmere St. ADDRESS

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.

