

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

Do not use this space.

29424

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St Louis** (No. **4216 Pleasant**)

File No.....
 Registered No. **8599**
 St..... Ward)

2. FULL NAME

Elsie Grief
 (a) Residence. No..... St. **10** 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widow</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>May 23rd 1893</i>				
7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<i>86</i>	<i>2</i>	<i>29</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at Home*
 (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) *Germany*

10. NAME OF FATHER

Not known

PARENTS

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

14. INFORMANT

(Address) *William A Grief 4216 Pleasant St*

15. FILED

19 *1929* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 22nd 1929*
 17. I HEREBY CERTIFY, That I attended deceased from *Aug. 2* 19*29*, to *Aug. 22* 19*29*.
 that I last saw h. or alive on *aug 21st 1929*, and that death occurred, on the date stated above, at *1:30 A. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Solar pneumonia

108
154/010
 (duration) - yrs. - mos. *7* ds.

CONTRIBUTORY (SECONDARY)

Senility

(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) *W. M. Winn* M. D.

8-22, 1929 (Address) *413 Wall Bldg.*

*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

Reverend

DATE OF BURIAL

Aug 26 1929

20. UNDERTAKER

Math Hermann 2 Sun 2161st Park

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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2
11

an

