

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

Do not use this space.

35737

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 7003

City St. Louis mo. No. City Hospital #2

File No.
Registered No. 10532
St. Ward)

2. FULL NAME

(a) Residence. No. 1213 N. 15th St. 25 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 10 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 col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hra. ormin.
<u>abt. 68</u>	<u>—</u>	<u>—</u>	<u>—</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work nil

(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) ala.

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER "

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

14. INFORMANT A. Gertrude Creath
(Address) City Hospital #2

15. FILED OCT 26 1929 Wm C. Jordan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/17/29

17. I HEREBY CERTIFY, That I attended deceased from 10-10-29 to 10-17-29 and that I last saw him alive on 10-17-29 and that death occurred, on the date stated above, at 7:30 am. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 931
chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 9003

(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) A. C. Hale M. D.

10/23/29 (Address) City Hospital #2

*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

Greenwood

Oct. 28 1929

20. UNDERTAKER

ADDRESS

J. H. Harrison

Lawton

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.

02