

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

Do not use this space.

35772

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No. **City Hosp. #2**)

File No.....
Registered No. **10570**
St. Ward)

2. FULL NAME

Eva (Collier) Roalier

(a) Residence. No. **4242 W. Belle** St., **11** 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 **Col** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **2-24-1885**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	44	8	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **girl**
(b) General nature of industry, business, or establishment in which employed (or employer). **Nurse.**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Ala**
(STATE OR COUNTRY)

10. NAME OF FATHER **Blats Jones**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

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

15. FILED **OCT 28 1929** REGISTRAR **O. Stankley**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10-25 19 29**

17. I HEREBY CERTIFY, That I attended deceased from **6-13** 19 **29**, to **10-25** 19 **29**, that I last saw her alive on **10-25** 19 **29** and that death occurred, on the date stated above, at **4:30 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of uterus
40 (duration) **1** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **46** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **Home**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Biopsy**
(Signed) **H.N. Weather** M. D.

10/26 19 29 (Address) **City Hosp. #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

Washington Park DATE OF BURIAL **Oct 28 19 29**

20. UNDERTAKER **Lewis Wehrle** ADDRESS **707 N Leonard**

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.

