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

Do not use this space.

35912

File No. 10722

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis (No. City Hospital, St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Della Larsen

(a) Residence. No. 5342 Clackson St., 19 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1865

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) V. 3 - 1897

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	8	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER John Williams

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

12. MAIDEN NAME OF MOTHER Lizzie Hallay

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

14. INFORMANT E. Larsen
(Address) City Hospital

15. FILED NOV - 1 1929, 19 Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929 to Oct 31, 1929 that I last saw he alive on 19 and that death occurred, on the date stated above, at 2 35 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ovarian Cyst right non Infected Curettaiem
Malignant organism
General Peritonitis (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Nephritis
(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? Yes.
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Edward Wellbing M. D.
(Address) City Hospital

*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
Delafield Ill.	Nov 3 1929
20. UNDERTAKER Shepard Und Co	ADDRESS 1167 Hamilton Ave

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.

Larsen