

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

Do not use this space.

35928

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Registration District No. 1003

City St. Louis Mo. (No. City Hosp # 2)

File No. 10742

Registered No. 10742

2. FULL NAME Dora White

(a) Residence. No. 1427-Webster St. 21 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)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OR (OR) WIFE OF

Tommie White

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-24-1904

7. AGE

YEARS

24

MONTHS

10

DAYS

5

If LESS than day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Charleston

(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Henderson Whiteley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known

(STATE OR COUNTRY) Miss

12. MAIDEN NAME OF MOTHER Irene Wilker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Charleston

(STATE OR COUNTRY) Mo.

14. INFORMANT: Irene Whiteley

(Address) 1427-Webster St

15. NOV -2 1929

FILED 19.....

Max C. Stork
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 29 1929

17. I HEREBY CERTIFY, That I attended deceased from..... 19..... to..... 19.....

that I last saw him..... alive on..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis
due to self induced abortion
140 (duration).....

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DEATH CONTRA... (duration)..... yrs..... mos..... ds.

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kerner M.D.
10/31, 1929 (Address) Dep. Corona

*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

Nov 3rd 1929

20. UNDERTAKER

R. S. Best and Co.

ADDRESS

2726 Subur

Every item of information should be carefully checked EXACTLY. PHYSICIANS should state fact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly understood.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 991 File No.
Township..... Primary Registration District No. 1003 Registered No. 10742
City St. Louis (No.) St. Ward)

2. FULL NAME

(a) Residence. No. St. 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) yrs. mos. ds.
(c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. JAN 30 1932 FILED 19 Max C. Hankley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1929
17. No Physician Attended
HEREBY CERTIFY That I attended deceased from

19..... to 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. W. Keener M. D.

124, 1929 (Address) Dep. Coroner

*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

20. UNDERTAKER ADDRESS

N. P. WRITE PERFECT WITH SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS' EXACT STATEMENT OF OCCUPATION IS VITAL. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' EXACT STATEMENT OF OCCUPATION IS VITAL.

SUPPLEMENTARY

1929
35928