

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

Do not use this space.

35943

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... *St. Louis, Mo* (No. *City Hospital #2*)

File No.

Registered No. **10789**

St. Ward)

2. FULL NAME

(a) Residence. No. *22 So. Leonard* / *18* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *20* 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)

Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-10-1873*

7. AGE

YEARS *56*

MONTHS *5*

DAYS *20*

IF LESS than 1 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)

(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *William Noble*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Nellie Thompson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Mo*

14. INFORMANT *A Gertrude Cepath*

(Address) *City Hospital #2*

15. NOV - 1 1929 FILED *Max C. Barker*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/30/1929*

17. *10-30-1929* HEREBY CERTIFY, That I attended deceased from *10-30-1929*

that I last saw her alive on *10-30-1929* and that death occurred, on the date stated above, at *1245 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
736
(duration) *6* yrs. *6* mos. *—* ds.

CONTRIBUTORY (SECONDARY)

(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. E. Hale* M. D.

(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

Rather Dickson *11/4 1929*

20. UNDERTAKER

ADDRESS

Russell Lund Co *2732 Pine*

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.

