

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

Do not use this space.

38356

1. PLACE OF DEATH
 County St. Louis Registration District No. 1170
 Township Wickman Primary Registration District No. 624877 File No. _____
 City W (No. 1505 Collins Ave) St. _____ Registered No. 782
 (Usual place of abode) (If nonresident, give city or town and State)
 2. FULL NAME Lydia Ann Combe
 (a) Residence. No. 1505 Collins St. _____ Ward. _____
 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles J. Combe
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 24, 1892
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 6 16
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. None
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

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

10. NAME OF FATHER John Hunter
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Penn.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Charles Combe
 (Address) 6234 Drexler Ave

15. FILED 11/12, 1929 L. P. Jensen
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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 16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 1929
 17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Nov 10, 1929 that I last saw her alive on Nov 9, 1929 and that death occurred, on the date stated above, at 7:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Hemorrhage
Postural Hemorrhage
7513
1130 (duration) _____ yrs. _____ mos. _____ ds.
1278 Chronic alcoholism
 CONTRIBUTORY (SECONDARY) (duration) 20 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 666 B
 IF NOT AT PLACE OF DEATH.
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) L. H. Coffey M. D.
Nov 12, 1929 (Address) 4000 Bess Ave

*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 Valhalla Cemetery DATE OF BURIAL Nov 12, 1929

20. UNDERTAKER Drehmann / Sarah ADDRESS 1905 Union

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.

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Dr. R. A. Camp
Cal 1350
4000 Green
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6:30 PM