

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

Do not use this space.

38632

1. PLACE OF DEATH

County _____ Registration District No. **791**

Township _____ Primary Registration District No. **1003**

City **St. Louis mo. City Hospital # 2** (No. _____) St. _____ Ward _____

File No. _____

Registered No. **11036**

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. **2204 Clare St.** **11** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. **2** mos. **2** 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)

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

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

9-7-29

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

—

2

2

8. OCCUPATION OF DECEASED

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

(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

Morse West

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ill.**

12. MAIDEN NAME OF MOTHER

Lucille Gray

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Miss**

14. INFORMANT

A. Gertrude Creath

(Address) **City Hospital # 12**

15. FILED

NOV 12 10 20 AM 1929

W. C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **11-9-29**

17. I HEREBY CERTIFY, That I attended deceased from **11-7-** **1929**, to **11-9-** **1929** that I last saw **her** alive on **11-6-** **1929**, and that death occurred, on the date stated above, at **2:10 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Compression

180 B

(duration) yrs. _____ mos. **4** ds.

CONTRIBUTORY (SECONDARY) **Cerebral Hematoma**

(duration) yrs. _____ mos. **26** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE **no**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & X-Ray**

(Signed) **W. C. Stanley**, M. D.

, 19 (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

Washington Park

DATE OF BURIAL

11/12 1929

20. UNDERTAKER

Traylor Und. Co

ADDRESS

3100 Franklin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' REPORTS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SECRET
11-11-60

SECRET
11-11-60

**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. 791 File No.....
 Township..... Primary Registration District No. 1003 Registered No. 11036
 City St. Louis (No.....) St..... Ward.....

2. FULL NAME Helen West
 (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 S
(write the word)

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. ormin.

8. OCCUPATION OF DECEASED

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

(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)

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. FILED Jan 14 1930 Max C. Starkloff
 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 9 1929

17. I 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:

Coronary Compression
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Birth Injury
 information given over phone by Dr. A. C. Hale duration yrs. mos. ds.
 Dr. of U. S. - 1-13-30

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? 16113

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*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. B.—Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIANS & REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

SUPPLEMENTARY

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