

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

Do not use this space.

38763

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 11182
St. 24th Ward

2. FULL NAME

(a) Residence. No. 2721 No-12th St. 26 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 2 - 1900

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
29 7 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(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) unknown

PARENTS

10. NAME OF FATHER ?

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

12. MAIDEN NAME OF MOTHER ?

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

14.

INFORMANT C. Sheridan
(Address) ISOLATION HOSPITAL

15.

NOV 16 1929 Max C. Stender
FILED 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-15 19 29

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 19 29 to Nov 15 19 29
that I last saw him alive on Nov 15 19 29, and that death occurred, on the date stated above, at 10:45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

13 yr (duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Alfred Hill, M. D.

11-16 19 29 (Address) ISOLATION 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

Popular Bluff Mo Nov. 17 19 29

20. UNDERTAKER ADDRESS 1417

Key Lechner Undl Co. 1st Market

WRITE MAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

235

31

