

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

Do not use this space.

39290

1. PLACE OF DEATH

County.....
Towship.....
City St. Louis (No. Isolation Hospital)
Registration-District No. 701
Primary Registration District No. 1003

File No.
Registered No. 11984
St. Ward)

2. FULL NAME Bennie May Elizondo

(a) Residence No. 1418 Locust Street St. 215 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 15, 1927

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min.
2 7 1

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) Chicago (STATE OR COUNTRY) Ills.

10. NAME OF FATHER Benjamin P. Elizondo

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

12. MAIDEN NAME OF MOTHER Rosalie Caney

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

14. INFORMANT Rosalie E. Elizondo (Address) 1418 Locust Street

15. FILED 1329 Max C. Harker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 16 19 29

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 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Bronchopneumonia
Secondary
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Concussion of Brain - due to fall to the floor
Accident
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 159 IF NOT AT PLACE OF DEATH.....

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

19. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. Kerne M.D.
1219 19 29 (Address) Rep. 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 St. Matthews Cemetery DATE OF BURIAL Dec 9 19 29

20. UNDERTAKER J. A. Getten L & Co. 7847 Meramec St. ADDRESS

WRITE PLAINLY, 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.

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