

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

Do not use this space.

42453

1. PLACE OF DEATH

County 1605 Glasgow Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis (No. _____) St. _____ Ward _____

File No. _____
Registered No. 12185

2. FULL NAME

Mary Steward
(a) Residence. No. 1603 Glasgow St. 20 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 colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 24, 1882

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
	<u>47</u>	<u>7</u>	<u>18</u>	

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) St. Charles
(STATE OR COUNTRY) MO

10. NAME OF FATHER Lewis Miller

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

12. MAIDEN NAME OF MOTHER Jarrett Channing

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

14. INFORMANT Alfred Steward
(Address) 1603 Glasgow

15. FILED DEC 15 1929 Max C. Staker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 12 1929

17. I HEREBY CERTIFY, That I attended deceased from 12 to 12 1929
4 that I last saw her alive on Chse 12, 1929, and that death occurred, on the date stated above, at St. Louis m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis

Personal knowledge (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) BBB (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 Symptom
(Signed) J. H. Matthead M. D.
, 19 _____ (Address) 1015 Jefferson

*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 Greenwood DATE OF BURIAL Dec 15 1929

20. UNDERTAKER Reverent - son ADDRESS 2700 Wash St.

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.

