

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

Do not use this space.

42456

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 003
(No. St. Johns Hosp.)

File No. 12188
Registered No. 12188
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 4878 Delmar St., 12 Ward.

(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 Gusie Boland.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 18 - 1896

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>33.</u>	<u>10</u>	<u>25</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Proprietor.
(b) General nature of industry, business, or establishment in which employed (or employer). Beauty Parlor
(c) Name of employer

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

10. NAME OF FATHER Wm. Lewis

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

12. MAIDEN NAME OF MOTHER Engie Dilday

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

14. INFORMANT Gussie Boland
(Address) 4878 1/2 Delmar

15. FILED DEC 15 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-10-, 1929, to 12-13-, 1929 that I last saw h. alive on 12-12-, 1929, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Post operation shock.
Operation for fibroid Tumor of Uterus
non vitalig mark. (duration) yrs. mos. ds. 5 4 0

CONTRIBUTORY (SECONDARY) Cardiac failure (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF 12-10-29

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Robert H. Lamb M. D.

12/14 1929 (Address) 3900 Park

*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. DATE OF BURIAL Dec 16 1929.

20. UNDERTAKER Muller and Co ADDRESS 5113 Delmar

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.

WRITE FULLY, WITH NO ROOM FOR AMBIGUITY

