

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

Do not use this space.

42557

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 7003
City St. Louis (No. City Report)

File No.
Registered No. 12324
St. Ward)

2. FULL NAME

(a) Residence. No. 722 Maryland (Rd) 25 Ward.
(Usual place of abode)

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. (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) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
abt. 73

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). Unknown 196
(c) Name of employer. Unknown 196

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

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Dr. [Signature]
(Address) City Report

15. FILED DEC 18 1929 [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1929 to Dec 27 1929, that I last saw him alive on Dec 27 1929 and that death occurred, on the date stated above, at 11-45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture of the neck of the right femur from fall to 4th floor at home
accident (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 185 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 185
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF 5

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [Signature], M. D.
12/27/29 (Address) City Report

*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
12-18-1929

20. UNDERTAKER ADDRESS
E. Shannon 1424 Carol

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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RECORD

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