

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

Do not use this space.

42842

1. PLACE OF DEATH

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

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *12635* St. Ward)

2. FULL NAME

Mother Julia Collignon
(a) Residence. No. *Taylor & Maryland St.* Ward. *18*

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..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female *White* *Single*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 4th 1856*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 *6* *22*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Catholic Sister*
(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) *New York*

10. NAME OF FATHER *Francois Collignon*

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

12. MAIDEN NAME OF MOTHER *Marie Vantain*

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

14. INFORMANT *Mother Bernache* (Address) *Taylor & Maryland*

15. FILED *DEC 27 1929* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec, 26th 1929*

17. I HEREBY CERTIFY, That I attended deceased from *4th December, 1929, to Dec 26th, 1929* that I last saw him alive on *Dec 26th 1929*, and that death occurred, on the date stated above, at *2:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sobor Pneumonia
1595
10/10 (duration) yrs. mos. *21* ds.
CONTRIBUTORY (SECONDARY) *Senile Atrophy* (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* clinical

WHAT TEST CONFIRMED DIAGNOSIS *Ethanol*
(Signed) *E. E. ... M. D.*

Dec 27, 1929 (Address) *37 W Washington*

*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 *Cabary* DATE OF BURIAL *12-28 1929*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 Wash St*

K. 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 PLAINLY, WITH OMISSION OF UNNECESSARY DETAILS

9

Mr. E. W. Smith

3720 Lincoln St.

Dec 5 1910

2 PM