

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

Do not use this space.

1134

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Jackson Primary Registration District No. _____
 City St. Louis (No. 140862nd) St. _____ Ward) _____

File No. _____
 Registered No. 120
 St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 1668 E. 2nd St. 9 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

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 1877</u>		
7. AGE	YEARS	MONTHS
<u>52</u>		
	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Housewife (Ret)</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-6-30
 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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis
 (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER George Huff

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

12. MAIDEN NAME OF MOTHER Lezzie Horace

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

14. INFORMANT Leon Cameron (Address) 1668 E 2nd

15. FILED Jan 10 1930 M. M. Crowe REGISTRAR

18. WHERE WAS DISEASE CONTRACTED 129 W

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? No autopsy

(Signed) Deputy Coroner, M. D.

(Address) Deputy Coroner

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland Cem. DATE OF BURIAL 1/10 1930

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lydia

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.

235

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16/30

