

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

Do not use this space.

2951

**1. PLACE OF DEATH**

County..... Registration District No. 34  
Township..... Primary Registration District No. 1100  
City St. Louis Mo. (No. Deaconess Hospital)

File No.....  
Registered No. 401  
St. .... Ward)

**2. FULL NAME**

Infant Rector  
(a) Residence No. 2738 Ann Av St. 23 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 12 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
— — 1

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Infant  
(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) St Louis

10. NAME OF FATHER Hurley Rector

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

12. MAIDEN NAME OF MOTHER Mabel Ohme

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

14. INFORMANT Mr Hurley Rector  
(Address) 2738 Ann Av

15. FILED JAN 14 1930 Wm C. Taylor REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 13 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 13, 1930 that I last saw her alive on Jan 13, 1930, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

157B  
158 Spina bifida  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) renal debility  
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF .....  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Otto T. Walser, M. D.  
, 19 (Address) 1904 Park Ave

\*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  
Valhalla Cemetery Jan 14 1930

20. UNDERTAKER ADDRESS  
E. J. Schurz 3125 Lafayette

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 PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

