

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis, Mo.*

Registration District No. *701*  
Primary Registration District No. *1003*

File No. *3019*  
Registered No. *504*  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *1438 R. No. 21st St., 21* 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 *Cold*      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, ..... hrs. or ..... min.  
*About 28*

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)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bastrop La*

10. NAME OF FATHER *Jim Irvin*

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

12. MAIDEN NAME OF MOTHER *Emma Gardner*

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

14. INFORMANT *Emma Irvin*  
(Address) *1438 R. No. 21st Street*

15. FILED *16 1930* *May C. Haskins* REGISTRAR

**2) MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 13 1930*

17. *No Physician Attendance*  
HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him ..... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Septicemia following abortion*

CONTRIBUTORY (SECONDARY) *Whether Criminal or accidental*  
(Duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED *Ascertained*

IF NOT AT PLACE OF DEATH, DID OPERATION PRECEDE DEATH? ..... DATE OF .....  
*8/14/30*

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *J. W. Kerner, M.D.*  
*1/15 1930* (Address) *109 Corcoran*

\*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 *Bastrop La.*      DATE OF BURIAL *Jan 16 1930*

20. UNDERTAKER *A. L. Beal and Co*      ADDRESS *2726 Lucas Ave*

WRITE PLAINLY, IN UNFADING INK---THIS IS A PERMANENT RECORD

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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