

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

3410
Do not use this space.
3410
2839
File No. _____
Registered No. 908 St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis (No. City Hospital #2)

2. FULL NAME

(a) Residence. No. 29 S. Cuyler St. 18 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 <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 <u>John Gilbert</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11-2-1903</u>				
7. AGE	YEARS <u>26</u>	MONTHS <u>2</u>	DAYS <u>21</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (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) Miss

PARENTS	10. NAME OF FATHER <u>Mellishmoek</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Okla</u>
	12. MAIDEN NAME OF MOTHER <u>unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT A. H. Crath
(Address) City Hospital #2

15. FILED Jan 28 1930 W. C. Harker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-23 19 30

17. I HEREBY CERTIFY, That I attended deceased from 1-4 19 30 to 1-23 19 30 that I last saw h. alive on 1-23 19 30, and that death occurred, on the date stated above, at 5-28 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Encephalitis Lethargica

17 (duration) yrs. 1 mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. Walker M. D.
1/24. 1930 (Address) city Hosp #2

*State the DISEASE CAUSING DEATH, or indicate death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gothenckson DATE OF BURIAL Jan 29 1930

20. UNDERTAKER J. E. Pope ADDRESS 2931 Leno

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

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1-23
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