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

Do not use this space.

6455

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 1261

Township ..... Primary Registration District No. ..... Registered No. .....

City St Louis Mo (No. Bethesda Hoop St. ..... Ward)

2. FULL NAME Betty Jane Fuller

(a) Residence. No. ..... St., 18 Ward. Hardin Ill
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Baby

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 31 - 1929

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(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) Ill

PARENTS

10. NAME OF FATHER Charles Fuller

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

12. MAIDEN NAME OF MOTHER Martha Carnes

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

14. INFORMANT Martha Fuller
(Address) Hardin Ill

15. FILED ..... 19 Wm C. Harkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 6 1930

17. I HEREBY CERTIFY, That I attended deceased from 2/2/30, 1930, to 2/6, 1930, that I last saw her alive on 2/5, 1930 and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal obstruction
(congenital adhesions)
157D
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Congenital bands gradually constricted bowel (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF 2/5/30
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? operation
(Signed) W K Riley, M. D.
2/6, 1930 (Address) 3647 Vista St Louis Mo

*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
Hardin Ill	Feb 6 1930

20. UNDERTAKER	ADDRESS
Fred M Williams	4617 Delmar

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.