

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

Do not use this space.

6519

1. PLACE OF DEATH

County..... Registration District No. 107
 Township..... Primary Registration District No. 102
 City St. Louis, Mo. City Hospital #2 St. _____ Ward _____
 Registered No. 1334

2. FULL NAME

(a) Residence. No. 2303 Wash 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 12 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 Col 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) 5-9-1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
23 11 8 26

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) Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Anthony Valentin
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Lillie Jenkins
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

14. INFORMANT R. Kershner
 (Address) City Hospital #2

15. FILED 19 May 1930
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-12, 1930, to 2-5, 1930
 that I last saw h...e alive on 2-5, 1930 and that death occurred, on the date stated above, at 5 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Encephalitis lethargica
17 (duration) yrs. 3 mos. ds.

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

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. H. Weather, M. D.

2/6, 1930 (Address) City Hospital #2
 *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 Fatherdekson DATE OF BURIAL Feb 9 1930

20. UNDERTAKER J. E. Ope ADDRESS 2931 Lucas

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.

