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

Do not use this space.

6742

File No. 1569

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis Mo. (No. 4643 Ray Av St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Mrs Mary Colclozier

(a) Residence. No. 4643 Ray Ave St., 15 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-27-69

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	60	4	17	

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) St Louis

PARENTS

10. NAME OF FATHER Frank Stroker

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Mrs J Colclozier
(Address) 4643 Ray Ave.

15. FILED ..., 19.. Max C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 14, 1930

17. No Physician in attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....

that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 4.40 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

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93C (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) G. W. Kerner, M.D.

2/14, 1930 (Address) Dep. Corner

*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
Calvary	2-17 1930
20. UNDERTAKER	ADDRESS
Hy Lidner Mnd. Co.	1417 N. Market St

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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