

APR 23 1930

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

Do not use this space.

7907

1. PLACE OF DEATH

County Waller
Township Jessamine
City Mo. (No. _____)

Registration District No. 104
Primary Registration District No. 3000

File No. _____
Registered No. 59
St. _____ Ward _____

2. FULL NAME

Ida Speakman

(a) Residence No. St. Charles Mo. St. _____ Ward State Hospital No. 1
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 7 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

abt 48

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Keeper
(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)

Mo.

10. NAME OF FATHER

J. K.

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

Mo.

12. MAIDEN NAME OF MOTHER

J. K.

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

Mo.

14. INFORMANT (Address)

St. Charles Hospital No. 1
Jessamine Mo.

15. FILED

3-14 1930

R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1930, to Mar 14 1930, that I last saw h. alive on Mar 14 / 1930, and that death occurred, on the date stated above, at 11 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular Lung
23A
31 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

No

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) R. N. Crews M. D.
19 St. Charles Hospital No. 1

*State the DISEASE CAUSING DEATH, or in 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

St. Charles Mo.

DATE OF BURIAL

3/16 1930

20. UNDERTAKER

Henry Mahanow

ADDRESS

St. Peters Mo.

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.

18 East 10 St

Rm, lease Dr

Crews

near Syn to

