

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

Do not use this space.

10334

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **003**
City..... **St. Louis Mo.** (No. **3756a**, **So. Broadway**)

File No.....
Registered No. **8311**
St..... Ward.....

2. FULL NAME Eliza Ann Heath

(a) Residence No. **3756a, So, Broadway** St. **24** Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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 Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Heath		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec, 20/1847		
7. AGE YEARS 82	MONTHS 2	DAYS 9
If LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... **House Wife**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... **Oak Town** **Indiana**
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER wilson McClellan
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
	12. MAIDEN NAME OF MOTHER Unknown
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT..... **Emmett M. Andrews**
(Address) **3756a, So, Broadway**

15. FILED..... **11** 19..... **1930**
W. C. Starker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 1, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 15**, 19**30**, to **March 1st**, 19**30**, that I last saw him alive on **March 1st**, 19**30**, and that death occurred, on the date stated above, at **9 P** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocardial
9:30
164

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

(duration) yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED **908**
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? DATE OF.....

19. WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Joseph L. Ferris, M.D.**
3/2 19**30** (Address) **4209 Virginia Ave.**

*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 **Lawrenceville Ill.** DATE OF BURIAL **3/4/30**

20. UNDERTAKER **Lyman W. Emman** ADDRESS **Lawrenceville Ill.**

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.

2
31

