

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

Do not use this space.

10391

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **353**

City **St. Louis Mo.** (No. **St. Mary's Infirmary** St. Ward)

File No.

Registered No. **2371**

2. FULL NAME

Margaret Thompson

(a) Residence. No. **3420 Washington Pl.** 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 **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov 22-1891**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	38	3	12	

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) **Missouri**
(STATE OR COUNTRY)

10. NAME OF FATHER **Unknown Hart**

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

12. MAIDEN NAME OF MOTHER **Sadie Wiley**

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

14. INFORMANT **Mr. B. Thompson**
(Address) **3420 Washington Ave**

15. FILED **19** **May C. Staker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-6-1930**

17. I HEREBY CERTIFY, That I attended deceased from **2-27**, 19**30**, to **3-6**, 19**30** that I last saw **her** alive on **3-6**, 19**30** and that death occurred, on the date stated above, at **1:15 p.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

a) Chronic nephritis & Heart enlargement secondary due to Chronic Nephritis
131 (duration) yrs. **1** mos. ds.

CONTRIBUTORY (SECONDARY) **Chronic Myocarditis**
(duration) **2** yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED **at home**
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **Pathol. & bacteriology**
(Signed) **S. Keigel**, M. D.

3-6, 19**30** (Address) **1536 Papan St.**

*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 **Calvary Cemetery** DATE OF BURIAL **March 8 1930**

20. UNDERTAKER **E. J. Schmitt** ADDRESS **3125 Lafayette Ave**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

