

MAY 28 1930

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

Do not use this space.

13909

1. PLACE OF DEATH *St Louis*  
 County.....*St Louis*..... Registration District No. *790*  
 Township *Central*..... Primary Registration District No. *6033*  
 City.....(No.....)..... St.....(Ward.....)

2. FULL NAME *Elvira Dickens*  
 (a) Residence. No. *Rack Key Manchester Rd.*..... Ward.....  
 (Usual place of abode)..... (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*  
 4. COLOR OR RACE *W*  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar - 4 - 1844*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hra. or .....min.  
*86 1 9*

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) *Own home*  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....  
 (STATE OR COUNTRY) *Tenn.*

10. NAME OF FATHER *James Kutzman*

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

12. MAIDEN NAME OF MOTHER *Maria Manak*

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

14. INFORMANT *Charles Wilming*  
 (Address) *Webster Groves, Mo*

15. FILED *ap. 14 1930* *K. W. Sullivan* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr - 13 1930*

17. I HEREBY CERTIFY, That I attended deceased from.....  
*April 13*, 1930, to....., 19.....  
 that I last saw her..... alive on..... *April 13*, 1930 and that death occurred, on the date stated above, at..... *9:30 P. M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*apoplexy*  
 (duration) yrs. mos. ds. *6 wks.*

CONTRIBUTORY (SECONDARY) *Senility*  
 (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?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... *N. K. Williams, M. D.*  
*Apr. 17*, 1930 (Address) *Webster Groves Mo*

\*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.....  
*Bethel Cem. Pond, Mo* *Apr. 16 - 1930*

20. UNDERTAKER..... ADDRESS.....  
*Schrader Und Co Ballwin Mo*

K. 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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1930-4-13

~~18~~ 4-3-21

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