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

Do not use this space.

14149

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 3481

Township ..... Primary Registration District No. 1003 Registered No. .....

City St. Louis (No. ISOLATION HOSPITAL St. 24th Ward)

2. FULL NAME Marion Degonia

(a) Residence. No. De Soto, Mo. Route 2 13 Ward. De Soto Mo.
(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 E. Degonia

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 21-1879

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	50	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(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) Missouri

PARENTS

10. NAME OF FATHER Joe Politt

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

12. MAIDEN NAME OF MOTHER Pauline Missey

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

14. INFORMANT Joe Raffler
(Address) ISOLATION HOSPITAL

15. FILED APR 7 1930 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-6 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-4, 1930, to 4-6, 1930 that I last saw her alive on 4-6, 1930, and that death occurred, on the date stated above, at 10:55 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis, Meningococcus
18
24 (duration) ..... yrs. ..... mos. 7 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Bil Kirkbrel, M. D.
4-7, 1930 (Address) ISOLATION HOSPITAL

*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 De Soto Mo	4/7 1930

20. UNDERTAKER	ADDRESS
Richardson Mettershead	De Soto 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.