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

Do not use this space.

14361

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 3704.

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

City St. Louis Mo. (No. City Hospital #1 St. ..... Ward)

2. FULL NAME Sophie Orene Tojo

(a) Residence. No. 1237 So. 8th, St., 22 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	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 Fred Tojo

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/27/1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	20	0	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Factory Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Haller Bird Seed Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Flat River
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Wm, Maness
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Amy Adams
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT Fred Tojo
(Address) 1237 So. 8th St.

15. FILED APR 14 1930 Max C Donkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-13 1930

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock + Injuries (Ruptured Liver) struck by auto in St. Louis Mo.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Homicide
..... (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? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Kerner, M.D.
4/14, 1930 (Address) Dep Corner

*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
Flat River Mo.	4/15/30

20. UNDERTAKER	ADDRESS
McLaughlin	1631 Mo. ave.

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.