

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

Do not use this space.

14379

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St Louis Mo.** (No. **2129A. S. 3rd St**)

File No.....
Registered No. **3723**
St. Ward)

2. FULL NAME

Mildred Julia Baldwin

(a) Residence. No. **2129A S 3rd** St., **23** 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 29th 1929**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— 3 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at Home**
(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) **St Louis Mo**

10. NAME OF FATHER **Harry Baldwin**

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

12. MAIDEN NAME OF MOTHER **Ruth Bucher**

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

14. INFORMANT **Harry Baldwin**

(Address) **2129A S. 3rd St.**

15. **APR 14 1930** FILED **Mary C. Husky** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 14 1930**

17. **No PHYSICIAN IN ATTENDANCE,** I HEREBY CERTIFY, That I attended deceased from

..... 19....., to..... 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at **9:20 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Primary Bronchopneumonia

CONTRIBUTORY (SECONDARY) **1000** (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? **No**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **[Signature]** M.D.

414, 19 **30** (Address) **Deputy Coroner**

*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

St Peter & Paul C. **April 15 1930**

20. UNDERTAKER ADDRESS

J. H. Gibson & Co. 2628 Lyman

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