

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

Do not use this space.

14469

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **ST. LOUIS, MO.**

(No. **4413**, **FARLIN AVE.**)

File No.

3813

Registered No.

St. Ward)

2. FULL NAME MARGARETTA GILLETTE.

(a) Residence. No. **4413 FARLIN AVE.** St. **10** 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)

WIDOWED.

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

ELMER H. GILLETTE.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **8/30/1851.**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

78

7

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). **SELF.**

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **IRELAND.**

10. NAME OF FATHER

DAVID CARROLL.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **IRELAND.**

12. MAIDEN NAME OF MOTHER

HANORA CONNORS.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **IRELAND.**

14.

INFORMANT

(Address)

**Thos E Gillette
4413 Farlin Ave**

15.

FILED

PR 16 1930

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/15/30** 19

17. HEREBY CERTIFY, That I attended/deceased from **Apr 8th** 19**30** to **Apr 15** 19**30** that I last saw her alive on **Apr 15** 19**30**, and that death occurred, on the date stated above, at **9-30** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A
167.
broncho pneumonia (duration) yrs. mos. **4** ds.
CONTRIBUTORY **7 days**
(SECONDARY) **a similar** (duration) yrs. mos. **7** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH. DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

John W. New-ham
4/16. 19 30 (Address) **4400 Washington**

*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

BRUSSELS, ILLINOIS.

4/18/30

20. UNDERTAKER

ADDRESS

Provost Burd Co **3710 N Grand.**

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.

WHITE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

