

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

Do not use this space.

14636

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. City Hosp. #2)
 St. Ward)

File No.
 Registered No. 4012
 St. Ward)

2. FULL NAME

(a) Residence. No. 2349 Clark St. 22 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 Col 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) 4-20-1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 9 hrs. or 40 min.

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER Laura Mae Bone Shelby

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

14. INFORMANT A. G. ...
 (Address) City Hospital #2

15. FILED APR 22 1930 New City REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-21 1930
 17. I HEREBY CERTIFY, That I attended deceased from 4/20 1930 to 4/21 1930
 that I last saw h. u. alive on 4/21 1930 and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature
159 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 161 W (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) A. E. Hale M.D. M. D.
4/21 1930 (Address) City Hosp. #2

*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 NOTHING KNOWN DATE OF BURIAL 4-24-1930

20. UNDERTAKER Ray Aston - 2945 Lawton ADDRESS

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.

31
2

