

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

Do not use this space.

14654

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 903

City St. Louis (No. City Hospital)

File No.

Registered No. 4049

St. Ward)

2. FULL NAME

(a) Residence. No. 3502 St. Louis Ave St. 11 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10 - 1930

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

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
- (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)

10. NAME OF FATHER Clyde Hoyt

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

12. MAIDEN NAME OF MOTHER Grace Miller

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

14. INFORMANT Ed Moran (Address) City Hospital

15. FILED 4-14 23 1930 REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11 1930

17. I HEREBY CERTIFY, That I attended deceased from April 10 1930 to April 11 1930 that I last saw her alive on April 11 1930 and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity
about 6 1/2 to 7 months,
150 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1610 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

4/12 1930 (Signed) Ben Margolis, M. D. (Address) City 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

FUTURE FIELD.

DATE OF BURIAL

4-24 1930

20. UNDERTAKER

Bernard Bernides

ADDRESS

1426 barrel

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.

WRITE PLAINLY WITH CONVICIONS

Kytr.