

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

Do not use this space.

14757

1. PLACE OF DEATH

County..... Registration District No. 781
 Townshp..... Primary Registration District No. 1002
 City St. Louis (No. 4) City separated 2
 St. Ward)

File No.
 Registered No. 4166
 St. Ward)

2. FULL NAME

Clara Julia Greer
 (a) Residence No. 3824 Windsor 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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-29-1871

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>58</u>	<u>9</u>	<u>25</u>	

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

9. BIRTHPLACE (CITY OR TOWN) S.C.
 (STATE OR COUNTRY)

10. NAME OF FATHER Adam Westfield

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

12. MAIDEN NAME OF MOTHER Mary Sloane

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

14. INFORMANT W. H. ...
 (Address) City Hospital #2

15. FILED APR 29 1930 W. C. ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/24 1930

17. I HEREBY CERTIFY, That I attended deceased from 4/24 1930 to 4/24 1930 that I last saw him alive on 4/24 1930 and that death occurred, on the date stated above, at 11:15 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Contributory
hypertension (duration) 5 yrs. 5 mos. ... ds.
diabetic gangrene 4-23-30

59 (duration) 1 yrs. ... mos. ... ds.
 PRIMARY CAUSE OF DEATH Diabetes Mellitus

SECONDARY ... (duration) 1 yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

2 DID AN OPERATION PRECEDE DEATH? No DATE OF 4 23 30

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. H. ... M. D.

4/23 19 (Address) City Hospital #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 St. Smith Ark. DATE OF BURIAL 4/27 1930

20. UNDERTAKER Peoples Und. Co. ADDRESS 3100 Franklin

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.

