

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

Do not use this space.

17798

1. PLACE OF DEATH

County

Registration District No. **791**

Township

Primary Registration District No. **1003**

City **St. Louis** (No. **City / Ward**)

File No.
Registered No. **4906**
St. Ward)

2. FULL NAME

(a) Residence No. **3508 279** St. **26** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **7** 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)

Widow

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

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

Dec 15 1897

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

32

5

4

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).

1143

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mexico

10. NAME OF FATHER

Jasquel Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mexico

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mexico

14. INFORMANT

(Address)

May C. Staver
City / Ward

15. DATE OF DEATH

FILED

19 1930

May C. Staver

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 19 1930*

17. I HEREBY CERTIFY, That I attended deceased from *May 10 1930* to *May 19 1930* that I last saw him alive on *May 19 1930* and that death occurred, on the date stated above, at *542 Ave.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lung Abscess (non-tuberculous) from infection (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *cause unknown* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *1073 Ave*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF ... WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical* (Signed) *Carl W. Hart*, M. D.

19 1930 (Address) *City / Ward*

*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 *Calvary Cem* DATE OF BURIAL *May 21 1930*

20. UNDERTAKER *Edward Koch* ADDRESS *3516 N. 4th St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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Cadena

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