

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

Do not use this space.

18183

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. Bethesda Hospital) St. _____ Ward _____

File No. _____
 Registered No. 5345

2. FULL NAME

(a) Residence No. _____ St. 18 Ward Hallsville Mo
 (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 1-1911

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>18</u>	<u>5</u>	<u>30</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Bever
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER W. H. Buchanan

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

12. MAIDEN NAME OF MOTHER Linda Howe

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

14. INFORMANT W. H. Buchanan
 (Address) Hallsville Mo

15. FILED JUN -1 1930
 _____ REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 5-31, 1930 that I last saw him alive on 6-31, 1930, and that death occurred, on the date stated above, at 11: A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute peritonitis (pneumococcus)
35A
129

(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (SECONDARY) Acute salpingitis (left)

Gonococcus (duration) _____ yrs. _____ mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF 5-28/30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? specimen

(Signed) W. H. Riley, M. D.

6/1 . 1930 (Address) 3647 Vista

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

Hallsville Mo June 1 1930

20. UNDERTAKER _____ ADDRESS _____

Fred Williams 4617 Delmar

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.

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