

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

Do not use this space.

206P2
20514

1. PLACE OF DEATH

County St. Louis
Township Central
City Maplewood (No. 7283 Anna Ave)

Registration District No. 786
Primary Registration District No. 4469

File No. _____
Registered No. 33
St. _____ Ward _____

2. FULL NAME

Lida R. Vincent

(a) Residence. No. 7283 Anna Ave St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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>Divorced</u>
5A. IF MARRIED, WIDOWED OR DIVORCED (OR) WIFE OF <u>J. Frank Vincent</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 7-1870</u>		
7. AGE YEARS <u>59</u>	MONTHS <u>9</u>	DAYS <u>19</u>
If LESS than 1 day, _____ hrs. or _____ min.		

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

9. BIRTHPLACE (CITY OR TOWN) Chertsey
(STATE OR COUNTRY) Illinois

PARENTS	10. NAME OF FATHER <u>Mortimer Milledge</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Sangamon Illinois</u>
	12. MAIDEN NAME OF MOTHER <u>Caroline Coon</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kane Illinois</u>	

14. INFORMANT Maill Vincent
(Address) 7283 Anna Ave

15. FILED 6/27, 1930 Maplewood, Mo
Merceda, St. Louis

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 26 1930

17. I HEREBY CERTIFY, That I attended deceased from June 9th, 1930, to June 25, 1930 that I last saw him alive on June 25, 1930, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
10 1/2 hrs (duration) _____ yrs. _____ mos. 30 ds.
CONTRIBUTORY (SECONDARY) High Blood Pressure
and cerebral anemia (duration) 1 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
(NAME AND PLACE OF DEATH) _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Dr. Theo F. Rieb, M. D.
6/27, 1930 (Address) 7465 Hazel Ave

*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 Valhalla DATE OF BURIAL June 28 1930

20. UNDERTAKER Parker and Co ADDRESS Webster Groves

WRITE PLAIN INK WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

