

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

Do not use this space
 20521
 20519

1. PLACE OF DEATH
 County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6033 B
 City Wallerstein (No. 6302, ella Ave) St. _____ Ward _____

2. FULL NAME Mrs Carrie Nite
 (a) Residence. No. 6302 Ella St. _____ 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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Nite
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 9 1861
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 | 6 | 21 | _____
 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
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
 10. NAME OF FATHER Don't Know
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Don't Know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 14. INFORMANT (Address) James Nite
6302 Ella Ave
 15. FILED 6/29, 1930 Rolla Bracy M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 1930
 17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1929 to June 27, 1930
 that I last saw her alive on June 27, 1930, and that death occurred, on the date stated above, at 8:15 P.M.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Carcinoma
46 yrs
69 yrs (duration) 1 yrs. 0 mos. 0 ds.
 CONTRIBUTORY (SECONDARY) Inanition - Gastric Hemorrhage - Acidosis
2 mos. (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED? _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? none
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab.
 (Signed) Luke B. Pierson, M. D.
6/28 1930 (Address) 3718 Jennings Rd.
 *State the DISEASE CAUSING DEATH, or if 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 Memorial Park Cem DATE OF BURIAL June 30 1930
 20. UNDERTAKER Jos. W. Clark ADDRESS 1125
Hodiamoni

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 UNFADING INK—THIS IS A PERMANENT RECORD

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