

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

Do not use this space.

20759  
5553

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **7023**  
City **St Louis, mo** (N. **City Hospital #223**)

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **3529 Clark St.** **18** Ward.

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred **21** 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 (write the word) **married**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
**abt 68** — —

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. **House-work**  
(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) **Ky**

**PARENTS**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **A. Gertrude Creath**  
(Address) **City Hosp #2**

15. FILED **JUN -7 1930** REGISTERAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-5-1930**

17. I HEREBY CERTIFY That I attended deceased from **6-2-1930** to **6-5-1930**  
that I last saw her alive on **6-5-1930** and that death occurred, on the date stated above, at **3 AM**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Chronic myocarditis**  
**92C**  
(duration) **1** yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) **90B**  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? **NO** DATE OF.....

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS **clinical**  
(Signed) **A. E. Stale**, M. D.

**6/5/1930** (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 **Trinity Protestant** DATE OF BURIAL **6-9-1930**

20. UNDERTAKER **W. H. ...** ADDRESS **20202**

WRITE PLAINLY, 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.

