

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

Do not use this space.
20959
21557
File No. _____
Registered No. **5777**
St. _____ Ward _____

**791
1003**

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis (No. City Hospital #1)

2. FULL NAME

(a) Residence. No. 3928 Delon St. 15 Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State) _____
Length of residence in city or town where death occurred 12 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Samuel</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 21 1862</u>					
7. AGE		YEARS <u>68</u>	MONTHS	DAYS <u>24</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Nihil</u> (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) <u>Kentucky</u>					
PARENTS	10. NAME OF FATHER <u>Leo C. Carny</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>				
	12. MAIDEN NAME OF MOTHER <u>Anna Sherd</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>				
14. INFORMANT (Address) <u>City Hospital</u>					
15. FILED <u>JUN 18 1930</u> <u>City Hospital</u> REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1930

17. I HEREBY CERTIFY, That I attended deceased from May 8 1930 to June 14 1930 that I last saw h. alive on June 14 1930, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Interruption of right femoral artery
Chronic myocarditis
due to fall to floor

CONTRIBUTORY (SECONDARY) at residence (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
Accident

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? clinical exam
(Signed) Edward Nelson M.D.
14. 1930 (Address) City Hospital

*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 <u>Cape Girardeau</u>	DATE OF BURIAL <u>6-16 1930</u>
20. UNDERTAKER <u>Homer Hud.</u>	ADDRESS <u>Cape Girardeau</u>

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.

Palmer