

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

Do not use this space.
20960
20158
File No. _____
Registered No. 5778
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis Mo. (No. City Hospital # 2)

2. FULL NAME

Lizzie Denton
(a) Residence, No. 1835 Franklin St. 21 Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 12 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 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) 5-12-1900
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 1 —
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) Ill
10. NAME OF FATHER Charlie Andersson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss
12. MAIDEN NAME OF MOTHER Annis Greene
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

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

15. FILED JUN 14 1930
REGISTRAR Max C. Stankoff

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-12-1930
17. I HEREBY CERTIFY, That I attended deceased from 6-7-1930 to 6-12-1930 that I last saw her alive on 6-12-1930 and that death occurred, on the date stated above, at 6:30 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS: 6:30 P.M.

Carcinoma of Rectum
(duration) — yrs. 18 mos. — ds.

CONTRIBUTORY (SECONDARY) _____ (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? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. E. Hale, M. D.

(Address) City Hospital # 2

*State the DISEASE CAUSING DEATH, and 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 Greenwood DATE OF BURIAL 6/16 1930

20. UNDERTAKER Bement son ADDRESS 2700 Wash st

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

