

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

Do not use this space.

21535
~~21537~~

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis, Mo. City Hosp #2 St. _____ Ward _____

File No. _____
Registered No. 7219
St. _____ Ward _____

2. FULL NAME

Baby Wagon
(a) Residence. No. 27 26 W. Adams St. 21 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. 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>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6-28-30</u>		
7. AGE	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, <u>12</u> hrs. or <u>40</u> min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Nil</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Herbert Wagon

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

12. MAIDEN NAME OF MOTHER Mildred Kenard

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

14. INFORMANT A. H. ...
(Address) City Hosp #2

15. JUL 21 1930 FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-29 1930

17. I HEREBY CERTIFY, That I attended deceased from 6/28 1930 to 6/29 1930 that I last saw her alive on 6/29 1930 and that death occurred, on the date stated above, at 11:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1610
Asphyxia
(duration) 15 hrs yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1622
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. H. ... M. D.
7/5 1930 (Address) City Hosp #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 POTTER'S FIELD DATE OF BURIAL 7-24-1930

20. UNDERTAKER Conyhton 2945 ... ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

