

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **ST. LOUIS** (No. **5800**) **ARSENAL**
City Parkway

File No. **24499**
Registered No. **6653**
St. Ward)

2. FULL NAME

NOFSINGER, Jennie
(a) Residence No. **5800 ARSENAL** St. **13** Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ?		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-24-1834		
7. AGE 96	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Hammer (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) Kentucky		
10. NAME OF FATHER R. J. Unknown		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) X		
12. MAIDEN NAME OF MOTHER X		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) X		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July-9 1930**

17. I HEREBY CERTIFY, That I attended deceased from **3/3/30**, 19....., to **July 9 - 1930** that I last saw her alive on **7/9/30**, 19....., and that death occurred, on the date stated above, at **4:30 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis.
936
99 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Atherosclerosis** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH,
19. DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Chas. O. Metz**, M. D.
7/10, 19**30** (Address) **Isolation Hospital**

14. INFORMANT **Mrs M. E. Hensley**
(Address) **5800 Arsenal St**

15. FILED **JUL 11 1930** **May C. Stanley** REGISTRAR

*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 **New Pickers** DATE OF BURIAL **July 11 1930**

20. UNDERTAKER **Clément and Leo S. Grand Blvd** ADDRESS **2317**

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.

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