

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

Do not use this space.

25192

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City..... (No. 2713 Walnut St)

File No. ....  
Registered No. 7417  
St. .... Ward)

**2. FULL NAME** Maggie Elliott

(a) Residence. No. 2713 Walnut St. 22 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE Col 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) June 23 1852

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
78 — 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Domestic  
(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) Miss. Tex

**PARENTS**

10. NAME OF FATHER Tom Lester

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

12. MAIDEN NAME OF MOTHER Corline Lester

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

**14.**

INFORMANT. Maggie Herring  
(Address) 2713 Walnut St

**15.**

FILED 11 24 1930 Wm C Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-20-1930

17. I HEREBY CERTIFY, That I attended deceased from 7-2-, 1930 to 7-20-, 1930 that I last saw her alive on 7-20-, 1930, and that death occurred, on the date stated above, at 5:15 a.m.

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

Chronic Interstitial Nephritis  
131  
1102

(duration) 1 yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)** ager

(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF no

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Dr. Edward Bee, M. D.

7-23-1930 (Address) 2901 E. 1st St. St. Louis, Mo.

\*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** Greenwood Cemetery **DATE OF BURIAL** 7/24/1930

**20. UNDERTAKER** Stins and Co

**ADDRESS** 3317 Morgan 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.

