

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

Do not use this space.

25314

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1703** File No.
 City **St. Louis** (No. **Deaconess Hospital**) Registered No. **7547** St. Ward)

2. FULL NAME

Hannah Sterrett
 (a) Residence. No. **6731 Wilson Ave** 3 Ward. (If nonresident, give city or town and State)
 (Usual place of abode)

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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Leander Sterrett**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 1, 1872**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 7 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Home**
 (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) **Mo**

10. NAME OF FATHER **Christ Sterrett**

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

12. MAIDEN NAME OF MOTHER **Unkown**

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

14. INFORMANT (Address) **Leander Sterrett 6731 Wilson Ave**

15. **Wm C Starker** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 26 1930**

17. I HEREBY CERTIFY, That I attended deceased from **July 1, 1930** to **July 26, 1930** that I last saw him alive on **July 26, 1930** and that death occurred, on the date stated above, at **6:10** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Inflammation of colon (ulcerative) no cancer or tuberculosis could be determined)
1074 (duration) yrs. mos. ds.
1200 Broncho-Pneumonia
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **W. Ray & Huerstrop** M. D.

1930 (Address) **2206 Howard St**

*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 **Valhalla Cemetery** DATE OF BURIAL **July 29 1930**

20. UNDERTAKER **Drehmann & Son** ADDRESS **1905 Union**

FILED **28** 1930

