

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

Do not use this space.

25368

1. PLACE OF DEATH

County

Registration District No. 791
1002

Township

Primary Registration District No.

City St. Louis (No. 4362)

Enright

File No.

Registered No. 7602

St. Ward)

2. FULL NAME

Loretta Laster

(a) Residence. No. 4362 Enright St. 19 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 Female 4. COLOR OR RACE Colored 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) Don't know

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>abt. 65</u>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(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) Ark.

10. NAME OF FATHER Thomas Davis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ark.

12. MAIDEN NAME OF MOTHER Edith Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ark.

14. INFORMANT G. J. Laster

(Address) 4362 Enright

15. FILED JUL 29 1930 W. C. Barker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25, 1930

17. No Physician attended
I HEREBY CERTIFY, That I attended deceased from.....

....., 19....., to....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 7 A...... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

90 B

(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?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Keme, M.D.

7/26, 1930 (Address) Dep. Curran

*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 OR REMOVAL

Buena Vista, Ark. DATE OF BURIAL 7/30/ 1930

20. UNDERTAKER

J. H. Harrison ADDRESS 2906 Lawton

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.

