

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

Do not use this space.

25497

1. PLACE OF DEATH

County St. Louis Mo Registration District No. 701
Township City Primary Registration District No. 4903
City St. Louis Mo (No. City)

File No. _____
Registered No. 7762
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 4112 Taylor St., 11 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 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) 7-3-1905

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>25</u>	<u>—</u>	<u>—</u>	<u>26</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) maid
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) ark

10. NAME OF FATHER Luke Dillard

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

12. MAIDEN NAME OF MOTHER Ester Webb

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

14. INFORMANT A. Glotzinger (Address) City Hospital #2

15. AUG -4 1930 FILED _____ REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-29 1930

17. I, HEREBY CERTIFY, That I attended deceased from 7-28, 1930, to 7-29, 1930, that I last saw h. e. alive on 7-29, 1930, and that death occurred, on the date stated above, at 5-30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heat of exhaustion

194 (duration) yrs. mos. ds. 1 ds.
CONTRIBUTORY (SECONDARY) Appendicitis
Appendicitis (duration) yrs. mos. ds. 1 ds.

18. WHERE WAS DISEASE CONTRACTED 191
IF NOT AT PLACE OF DEATH Home

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 7-28-30

WAS THERE AN AUTOPSY? Appendicitis

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. D. Matthews M. D.
7/29/30 (Address) Box #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 Washington Park DATE OF BURIAL Aug 4 1930

20. UNDERTAKER C. J. Gold ADDRESS 4107

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.

