

SEP 26 1930

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

Do not use this space.

27743

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Near Farmington, Mo.

Registration District No. 773
Primary Registration District No. 6018A

File No. _____
Registered No. 172
St. _____ Ward)

2. FULL NAME Elsie Kaub

(a) Residence No. 3444 Arsenal St. St. _____ Ward. _____
(Usual place of abode) St. Louis, Mo. (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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
50

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stage
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

14. INFORMANT Records of State Hosp. #4
(Address) Farmington Mo.

15. FILED Aug 14 1930 B. J. Robinson REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 13, 1930

17. I HEREBY CERTIFY That I attended deceased from March 26, 1930 to August 13, 1930 that I last saw h. er alive on August 13, 1930 and that death occurred, on the date stated above, at 8:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bichloride of Mercury poisoning,
Self administered, with suicidal
intent. 163D

54 (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY Insanity
(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? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Ralph Stankus M. D.

8/13/30 (Address) Farmington, 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 DATE OF BURIAL

St Louis Mo. Aug 15 1930

UNDERTAKER Farmington and Co. Farmington Mo
ADDRESS _____

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.

