

27782.a

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

Do not use this space.

27782.a

1. PLACE OF DEATH

County Waino
Towship St. Judas
City Knicks Park (No. _____)

Registration District No. 784
Primary Registration District No. 6030

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

2. FULL NAME

Michaela Montgomery
(a) Residence No. 2712 Sheridan St., _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work house wife
(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) Texas

10. NAME OF FATHER unknown

PARENTS

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT (Address) E.R. Montgomery
2712 Sheridan

15. Informant (Address) Dr. Carl J. Knauth
Finger No. _____, 19____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

suicide by firearm
173

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH St. Louis Park Mo

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS Physical signs
(Signed) John S. Gannett, M.D.

8/11, 1930 (Address) Cornell Springs Ga
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSED, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington University DATE OF BURIAL 8-14 1930

20. UNDERTAKER Reverent - son ADDRESS 2700 Wash

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FEB 23 1930

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