

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

Do not use this space.

28139

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St Louis (No. City Hospital)

File No.....

Registered No. 1979

St. 1979 Ward

2. FULL NAME

(a) Residence. No. 1011 Sedgewick St. 23 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

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

17. I HEREBY CERTIFY That I attended deceased from Aug 6, 1930, to Aug 9, 1930 that I last saw her alive on Aug 9, 1930 and that death occurred, on the date stated above, at 8:15 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8 - 1910

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 20 1 1

Intestinal obstruction due to adhesions between loops of Lower Ileum

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Maid 12

(duration) yrs. mos. ds. Adhesions due to a former operation for Appendicitis (duration) yrs. mos. ds.

(b) General nature of industry, business, or establishment in which employed (or employer)

18. WHERE WAS DISEASE CONTRACTED

(c) Name of employer

IF NOT AT PLACE OF DEATH

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 8/8/30

10. NAME OF FATHER Sam De Loue

WAS THERE AN AUTOPSY? No

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

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & operative

12. MAIDEN NAME OF MOTHER Fella Holloway

(Signed) Carl H. Hogg M. D.

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

819, 1930 (Address) City Hospital

*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.

14. INFORMANT Wm C Parkley

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Flat River mo.

(Address) City Hospital

DATE OF BURIAL 8-11 1930

15. FILED AUG 11 1930 Wm C Parkley REGISTRAR

20. UNDERTAKER McLaughlin 1631 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.

Meader.