

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

Do not use this space.

31703

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **70E1**
Primary Registration District No. **1003**
(No. **723 Dover Place**)

File No.....
Registered No. **9357**
St..... Ward)

2. FULL NAME

(a) Residence. No. **723 Dover Place** St. **15** 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 **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Dr Monte E. Etherton**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 7, 1885**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 4 20
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **at Home**
(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) **Illinois**

10. NAME OF FATHER **August Schradler**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**
12. MAIDEN NAME OF MOTHER **Sophia Davis**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ills**

14. INFORMANT **Monte E. Etherton M.D.**
(Address) **723 Dover Place**

15. FILED **SEP 29 1930** **Max C. Starker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 27 1930**

17. I HEREBY CERTIFY, That I attended deceased from **July 15**, 1930, to **Sept 27**, 1930 that I last saw him alive on **Sept 27**, 1930 and that death occurred, on the date stated above, at **3:20 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of 48 uterus (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **46** (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) **J. S. Pennard** M. D.

9/29/30 (Address) **3115 S Grand**

*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 **Sunset Burial Pl** DATE OF BURIAL **9-30-1930**

20. UNDERTAKER **Southern** ADDRESS **6320 S. Grand Blvd**

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.

Dr H. B. Remond
315 & 32nd