

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

Do not use this space.

34226

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No.....
 City..... *St. Louis City* (No. *Hoops #1*) St. Ward)

File No.....
 Registered No. **9566**

2. FULL NAME

(a) Residence. No. *Carr 1st St.* St. Ward. *23* *Vernice Ill*
 (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 *Albert Riggs*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 27/47-1905*
 7. AGE YEARS MONTHS DAYS LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housewife*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Louisville Ky.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Charles Bectol*

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

12. MAIDEN NAME OF MOTHER *Winkfourn*

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

14. INFORMANT *Bertha Lowman*
 (Address) *Vernice Ill.*

15. FILED *1907* 19. *Max C. Garklog* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 5 1930*
 17. *No Physician attended*
 I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at *8:50 a.m.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Chronic Endocarditis
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *Chronic Endocarditis*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? *POA*

8. DID AN OPERATION PRECEDE DEATH? DATE OF.....
 WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *J. W. Fenner* M.D.
 10/7/30 (Address) *Dep. Vernice*

*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 *Madison Ill.* DATE OF BURIAL *Oct. 7 1930*

20. UNDERTAKER *J. J. Lohy* ADDRESS *Madison Ill.*

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.

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