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.

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

Do not use this space.

34279

File No. 9630

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

City St Louis (No. City Hospital St. ..... Ward)

2. FULL NAME 10765 Mabel Lockman

(a) Residence. No. 3006 Glasgow St., 20 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 - 1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	57	7	24	

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

PARENTS

10. NAME OF FATHER Martin Lash

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

12. MAIDEN NAME OF MOTHER Mary Kaiser

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

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED ....., 19.... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 1930.

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Oct 8, 1930 that I last saw her alive on Oct 8, 1930, and that death occurred, on the date stated above, at 4 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus
Gangrene of Right Foot and Lower Leg.
3 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 57 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory Clinical & Operative

10/8 (Signed) Carl J Hoh M.D.
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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Oak Grove	Oct 10 1930
20. UNDERTAKER	**ADDRESS**
Ky Leidner Und Co	N. Market

Lockman