

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

Do not use this space.

37559

1. PLACE OF DEATH

County..... Registration District No. **70**
Township..... Primary Registration District No. **1098**
City St. Louis (No. Jewish Hospital)

File No.
Registered No. **10640**
St. Ward)

2. FULL NAME

(a) Residence. No. 835 N. Collins Rd. St. Louis Mo. 12 Ward. St. Louis Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 5 yrs. - 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Robert Brashear</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct. 29 - 1854</u>		
7. AGE	YEARS <u>79</u>	MONTHS <u>0</u>
	DAY <u>9</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>House-work</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8 1930
17. I HEREBY CERTIFY, That I attended deceased from Med 1 1929 to Nov. 8 1930 that I last saw he alive on Nov. 8 1930, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiomyopathy & Sub-maxillary Glands and 2° Urinary - Kidney Muscles (to my knowledge)
(duration) 1 yrs. 8 mos. - da.
CONTRIBUTORY Diabetic Mellitus To (SECONDARY)
My Knowledge (duration) 1 yrs. 8 mos. - da.

9. BIRTHPLACE (CITY OR TOWN) Maryland
(STATE OR COUNTRY)

10. NAME OF FATHER Geo. L. Bell

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

12. MAIDEN NAME OF MOTHER Elizabeth Shipley

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

18. WHERE WAS DISEASE CONTRACTED Glendale, Inkwood, Mo.
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF.....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) John H. ... M. D.
1-10 1930 (Address) Inkwood Mo

14. INFORMANT Lizzie B. Brashear
(Address) 835 N. Collins Rd. St. Louis Mo

15. FILED Nov 10 1930
REGISTRAR

*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 Bellefontaine Cemetery DATE OF BURIAL Nov. 11 1930

20. UNDERTAKER Louis H. Bopp ADDRESS Kirkwood Mo

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

