

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

Do not use this space.

37699

1. PLACE OF DEATH

County..... Registration District No. **701**
 Township..... Primary Registration District No. **1000**
 City **St Louis** (No. **13290 Webster Ave**) St. Ward)

File No.
 Registered No. **10788**

2. FULL NAME

(a) Residence. No. **13290 Webster Ave.** **21** 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 Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown		
7. AGE About 48	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) **Mo**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Frank Good**

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

12. MAIDEN NAME OF MOTHER **Lelama Childs**

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

14. INFORMANT **Estella Duncan**
 (Address) **1329 Webster Ave**

15. FILED **NOV 15 1930**
 REGISTRAR **W. J. Stender**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **11-11** 19**30**

17. HEREBY CERTIFY, That I attended deceased from **11-4** 19**30**, to **11-11** 19**30**, that I last saw her alive on **11-11** 19**30** and that death occurred, on the date stated above, at **3:30** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
131
from renal thrombosis (duration) yrs. mos. **7** ds.

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

18. WHERE WAS DISEASE CONTRACTED **1329 W**
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH. DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) **J. H. Harrison** M. D.
11-11 19**30** (Address) **8200 Laclede Ave**

*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 **Robertsville Mo** DATE OF BURIAL **11/16 1930**
 20. UNDERTAKER **A. Russell** ADDRESS **2732 Pine**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

