

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No.....) St..... Ward.....

File No. **37785**
 Registered No. **10890**

2. FULL NAME

Maggie Jones
 (a) Residence. No. **2710 Clayton** St., **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
 4. COLOR OR RACE
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female *col.* *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED NOV 19 1930

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **11/15 1930**

17. I HEREBY CERTIFY, That I attended deceased from **11-15-30**, 19**30**, to **11-16-30**, 19**30** that I last saw h..... alive on..... and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

mitral regurgitation

Personal knowledge (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *90%* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH **2710 Clayton St**

DID AN OPERATION PRECEDE DEATH? **m** DATE OF **1**

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. E. Edmunds*, M. D.

(Address) **1419 Morgan City**

*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 **E. St. Louis, Ill.** DATE OF BURIAL **11/19 1930**

20. UNDERTAKER **K. M. C. Green** ADDRESS **3577 Ladew Ave**

*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.

REGISTRAR

1100 P. 1000.

111th Street

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