

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

Do not use this space.

41759

1. PLACE OF DEATH

County..... St. Louis Registration District No. 843
Township..... Washington Primary Registration District No. 6106
City..... St. Louis (No.) St. Ward)

File No.
Registered No.
St. Ward)

2. FULL NAME

Mrs. Francis Meade
(a) Residence. No. St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city, or town and State)

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>married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John B. Meade</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 19 - 1861</u>					
7. AGE		YEARS		MONTHS	
		<u>69</u>		<u>8</u>	
		DAYS		IF LESS than 1 day, hrs. or min.	
		<u>14</u>			
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Domestic</u>					
(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) <u>St. Louis MO</u>					
PARENTS	10. NAME OF FATHER <u>Unknown</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>				
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 - 1936

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 - 1936 to Dec 5 - 1936, that I last saw her alive on Dec 4 - 1936, and that death occurred, on the date stated above, at 8 A. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Salmonellosis
108
936 (duration) yrs. mos. 2 da.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
(duration) yrs. mos. da.

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

19. DID AN OPERATOR DECIDE DEATH? No DATE OF Nov 6 1936
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) J. W. Scott M. D.
, 19 Dec 5 1936 (Address) St. Louis MO

*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
Providence - Lindbergh DATE OF BURIAL Dec 6 1936

20. UNDERTAKER
Wm. Stulting ADDRESS Providence

14. INFORMANT J. W. Scott
(Address) St. Louis MO

15. FILED..... 19..... REGISTRAR

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.

JAN 22 1937

RECEIVED
FEBRUARY 1951

1951

RECEIVED
FEBRUARY 1951

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Stone Registration District No. 843 File No.
 Township Washington Primary Registration District No. 6106 Registered No.
 City (No.) St. Ward)

2. FULL NAME

Nancy Francis Meade
 (a) Residence, No. St. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (*write the word*)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (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 Dec 6 1930 Flourence Scott REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 1930

17. 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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

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. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-41759