

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

Do not use this space.

**3061**

**1. PLACE OF DEATH**

County ..... Registration District No. **791**  
 Township **St. Louis** Primary Registration District No. **1008**  
 City **St. Louis** (No. **4516** **Genereve Ave** St. **7** Ward)

**2. FULL NAME**

(a) Residence No. **4516 Genereve Ave St. 7** Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)  
 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>None</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Dec 22 - 1927</i>		
7. AGE	YEARS <i>3</i>	MONTHS <i>0</i>
	DAYS <i>14</i>	IF LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <i>St. Louis</i> (STATE OR COUNTRY) <i>MO</i>		
PARENTS	10. NAME OF FATHER <i>Leslie Case</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <i>St. Louis</i> (STATE OR COUNTRY) <i>MO</i>	
	12. MAIDEN NAME OF MOTHER <i>Bernadine Edwards</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <i>St. Louis</i> (STATE OR COUNTRY) <i>MO</i>	

14. INFORMANT *Leslie Case*  
 (Address) *4576 Genereve Ave*

15. FILED *-7 1931*  
 REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 6 1931*  
 17. I HEREBY CERTIFY, That I attended deceased from *Dec 29*, 19*30*, to *Dec 6*, 19*31*, that I last saw him alive on *Dec 6*, 19*31*, and that death occurred, on the date stated above, at *2 a* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*8*  
*10*  
*Scarlet Fever*  
 (duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY) *Scarlet Fever*  
 (duration) yrs. mos. *7* ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....  
 WAS THERE AN AUTOPSY? *no*  
 WHAT TEST CONFIRMED DIAGNOSIS? *Varicella Culture*  
 (Signed) *H. K. Lewis M.D.*  
*11/6*, 19*31* (Address) *2076 Lufkin Blvd.*

\*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 <i>New Bethelhem</i>	DATE OF BURIAL <i>Jan 8 1931</i>
20. UNDERTAKER <i>Chas L. Lee</i>	ADDRESS <i>2707 N. Grand</i>

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.

7/5/5

OK  
M. J. J.