

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

Do not use this space.
3468

1. PLACE OF DEATH

County..... Registration District No. **191**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **2810 N. 12th St.**)..... St. Ward

2. FULL NAME *Minnie Chastain*

(a) Residence. No. **2810 N. 12th St.** St. **26** 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 **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 18 - 1881**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 10 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer) **107A**
(c) Name of employer **1068**

9. BIRTHPLACE (CITY OR TOWN)..... **Mo.**
(STATE OR COUNTRY) **1**

10. NAME OF FATHER **Mr. Henson**

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

12. MAIDEN NAME OF MOTHER **Mr. Henson**

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

14. INFORMANT **Geo. B. Chastain**
(Address) **2810 N. 12th St.**

15. FILED **JAN 18 1931** **New V. Starnes** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 17 1931**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 26**, 19**30**, to **Jan 17**, 19**31** that I last saw him alive on **Jan 16**, 19**31**, and that death occurred, on the date stated above, at **22** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Bronchial

107A (duration) **20** yrs. **8** mos. **20** ds.
CONTRIBUTORY (SECONDARY) **Bronchitis following**

Pneumonia April 1930 (duration) **8** yrs. **8** mos. **20** ds.
non tubercular

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? **Clinical**
(Signed) **J. D. Peifer** M. D.

1/17 1931 (Address) **2505 No 13th**

*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 **Freudens** DATE OF BURIAL **Jan 19 1931**

20. UNDERTAKER **Wm. Leidner and Co. N. Market St.** ADDRESS **1417**

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.

