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.

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

Do not use this space.

3474

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. ..... Registered No. 705

Township ..... Primary Registration District No. ..... St. ..... Ward)

City ..... (No. ISOLATION HOSPITAL

2. FULL NAME Deloris Flores Flores

(a) Residence. No. 4031 N. Broadway 26 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 Fem

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-8-29

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
1	2	9	

8. OCCUPATION OF DECEASED

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

(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) Mo.

PARENTS

10. NAME OF FATHER Petro Flores

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

12. MAIDEN NAME OF MOTHER Margie Regh

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

14. INFORMANT Joe Laffler (Address) ISOLATION HOSPITAL

15. FILED JAN 18 1931 Max C Harvey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-17 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1931, to Jan 17, 1931, that I last saw her alive on Jan 17, 1931, and that death occurred, on the date stated above, at 1:15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Measles

101A (duration) ..... yrs. ..... mos. 22 ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia

Secondary (duration) ..... yrs. ..... mos. 16 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? Clinical findings

(Signed) L. F. Kompare, M. D

, 19 (Address) ISOLATION HOSPITAL

*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 Calvary Cemetery

DATE OF BURIAL Jan 19th 1931

20. UNDERTAKER Edward Koch

ADDRESS 3516 4 14th