

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

Do not use this space.

8277

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1008**
 City *St. Louis* (No. *12119*) *St. Taylor*

File No.
 Registered No. **2670**
 St. Ward)

2. FULL NAME

Leticia M. Worthington
 (a) Residence. No. St. **11** 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widow</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Jos M. Worthington</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Feb 10 1837</i>		
7. AGE	YEARS <i>94</i>	MONTHS <i>15</i>
	DAYS <i>15</i>	
	IF LESS than 1 day, hrs. or min.	

8. OCCUPATION OF DECEASED

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

St. Louis County

10. NAME OF FATHER

Wm M. Walters

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

St. Louis County

12. MAIDEN NAME OF MOTHER

Mary Ann Sutherland

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

Virginia 2

14. INFORMANT (Address)

J. W. DeTusk
12119 St. Taylor

15. FILED

20 1919
May C. H. [Signature]
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 27 1937*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 26* **1937** **to** *Feb 27* **1937**.
 that I last saw *her* alive on *Feb 27* **1937**, and that death occurred, on the date stated above, at *3 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberc Pneumonia (Re-File)

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 symptoms*
 (Signed) *John C. Freund*, M. D.
 (Address) *2945 Franklin*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary* **DATE OF BURIAL** *Mar 2 1937*

20. UNDERTAKER *Hangan & Sheahan* **ADDRESS** *1444 B Washington*

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.

