

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

Do not use this space.

10449

1. PLACE OF DEATH

530 County Jefferson
Township Rock
City St. Louis (No.)

Registration District No. 423
Primary Registration District No. 5578

File No.
Registered No.
St. Ward

2. FULL NAME

Josephine Dalton

(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 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 Joseph Dalton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-20-1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>50</u>	<u>11</u>	<u>15</u>		

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) Housewife
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 10

10. NAME OF FATHER Anthony Meyer

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

12. MAIDEN NAME OF MOTHER Do not know

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

14. INFORMANT Lois Dalton
(Address) St. Louis Mo

15. FILED 3/6 1931 H. W. Eld
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/6 1931

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 4 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart failure - (Pneumonia)
111B
..... (duration) yrs. mos. ds.

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

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

8 DID AN OPERATION PRECEDE DEATH..... DATE OF WAS THERE AN AUTOPSY? (7)

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. H. Adams - St. Louis Mo
, 19 (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 Calvary DATE OF BURIAL 3/9 1931

20. UNDERTAKER Proctor Undertaking Co ADDRESS 3710 No. 7th

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.

APR 23 1931

AUG 28 1953

**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 Jefferson Registration District No. 423 File No.
 Township Rock Primary Registration District No. 5-578 Registered No. 7
 City (No.) St. Ward)

2. FULL NAME Josephine Salter

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-20-1880

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 19 Apr 1918 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/6 1918

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h. alive on 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart failure
Pneumonia
Apno-Static
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

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

N. B. Every item of information should be carefully classified. Exact status of OCCUPATION is very important. PHYSICIANS should file. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

6H501-5