

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

Do not use this space.

12557

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **ST. Louis** (No. **Deaconess Hospital**) St. Ward)

File No.
 Registered No. **3874**

2. FULL NAME

Infant Roe
 (a) Residence. No. **4049 Washington St.** **19** 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) Single		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 27, 1931				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
				15 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) St. Louis (STATE OR COUNTRY) Mo.				
PARENTS	10. NAME OF FATHER Carl Roe			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wetliugh (STATE OR COUNTRY) Ill.			
	12. MAIDEN NAME OF MOTHER Pearl Evans			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Carterville (STATE OR COUNTRY) Ill.			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 27** 19 **31**

17. I HEREBY CERTIFY, That I attended deceased from **3-27-31**, 19... to ... 19... that I last saw **her** alive on **3-27-31**, 19... and that death occurred, on the date stated above, at **7.15 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Misscarrage 5 mos.
159

CONTRIBUTORY (SECONDARY) **159**
 (duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Phy. Exam.**
 (Signed) **D. L. Jennings**, M. D.

3/28 . 19 **31** (Address) **4101 Washington Ave**

*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 St. Mathews Cemetery	DATE OF BURIAL 3, 30, 31 19
20. UNDERTAKER Thomas P. Schaffer	ADDRESS Sullivan

14. INFORMANT **Carl Roe**
 (Address) **4049 Washington Ave.**

15. FILED **29** 1931 **W. C. Stanley**
 REGISTRAR

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.

