

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

Do not use this space.

16371

File No. _____
Registered No. **4882**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1203**
City St. Louis (No. St. Johns)

2. FULL NAME Jean Ann Handlan

(a) Residence No. 1916 Warren St. St. 26 Ward _____

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. (If nonresident, give city or town and State)

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) May 15, 1930

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hrs. or _____ min.
1 11 5

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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) Missouri

10. NAME OF FATHER Norman Handlan

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

12. MAIDEN NAME OF MOTHER Florence Grauberg

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

14. INFORMANT Mr. Norman Handlan
(Address) 1916 Warren St.

15. FILED 23 May 1931
REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 20 1931

17. I HEREBY CERTIFY, That I attended deceased from ap. 1, 1931, to ap. 20, 1931, that I last saw him alive on ap. 3, 1931, and that death occurred, on the date stated above, at 5:50 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute otitis media
meningitis
secondary
(duration) yrs. mos. 21 ds.
(duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1916 Warren

DID AN OPERATION PRECEDE DEATH? yes DATE OF ap. 20/31
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Jos. J. Corlitta M. D.
(Address) Sister Bldg. St. Louis

*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 4-23 1931

20. UNDERTAKER Geo. L. Pleitach
ADDRESS 5966 Easton Ave.

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.

20. 6. 1911

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