

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

Do not use this space.

16576

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 1218 Parson) St. _____ Ward _____

File No. _____
 Registered No. 5099
 St. _____ Ward _____

2. FULL NAME

Stella May Rutledge
 (a) Residence. No. 1218 Parson Ave St. _____ Ward 23
 (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) Sept 13-1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
29 7 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk (confectionary)
 (b) General nature of industry, business, or establishment in which employed (or employer) not employed
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Colo. Co.
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Wm a Rutledge

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

12. MAIDEN NAME OF MOTHER Lenora Duncan

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

14. INFORMANT Wm a. Rutledge
 (Address) 1218 Parson Ave

15. FILED 21 1931 Max C. Rutledge REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1929, to Apr 27 1931, that I last saw her alive on Apr 26 1931, and that death occurred, on the date stated above, at 4:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
T.B.A.

History (duration) 3 yrs 6 mos ds.

CONTRIBUTORY (SECONDARY) Flu (duration) 3 mos ds. Prior to 513

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF X _____

WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Miscellaneous
 (Signed) M. J. [unclear] M. D.
 , 19 _____ (Address) 13756 Lindell

*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 Jefferson City, Mo. DATE OF BURIAL Apr 29 1931

20. UNDERTAKER Putz Bros 3029 Lafayette St ADDRESS

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

