

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

**791**  
**1003**

Township.....

Primary Registration District No.....

City *St. Louis* (No. *City Hospital*)

File No.....

**16615**

Registered No.....

**5138**

St.....

Ward.....

**2. FULL NAME**

(a) Residence. No. *321 So. Broadway 15* Ward.

(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)

*Not known*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*abt. 46*

8. OCCUPATION OF DECEASED

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

*nil*

(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)

*Not known*

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).....

FILED.....

19.....

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 22nd 1931*

17.

I HEREBY CERTIFY, That I attended deceased from *April 22nd, 1931* to *April 22nd, 1931*, that I last saw her alive on *April 22nd, 1931*, and that death occurred, on the date stated above, at *10.00* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chr. Myocarditis*

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) *George E. Johnson*, M. D.

*423*, 1931 (Address) *City Hosp.*

\*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

20. UNDERTAKER

ADDRESS

*St. Louis*  
*W. R. Ruster 3500 Putz*

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.

Rocks