

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

Do not use this space.

16679

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis,** (No. **Barnard Steiner Cancer Hosp.** St. **4th,** Ward)

2. FULL NAME Mrs. Isabella Small.

(a) Residence. No. **2628, Gamble,** St. ~~.....~~, Ward. **21**
 (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 Colored	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Benjiman F. Small,		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dont know,		
7. AGE abt. 39	YEARS 39	MONTHS
	DAYS 	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. House Wife, (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) **Indiana,**

PARENTS	10. NAME OF FATHER Peter M. Cole,
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Kentucky,
	12. MAIDEN NAME OF MOTHER Catherine Smith
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Kentucky,

14. INFORMANT..... **Benjamin F. Small,**
 (Address) **2628 Gamble, St. St. Louis,**

15. FILED..... 19 **May 2** **Stanley**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 29 th, 19 31**

17. I HEREBY CERTIFY, That I attended deceased from **21** 19**31** to **April 29** 19**31**
 that I last saw him alive on **April 29,** 19**31**, and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Benign Subacute ulcerus of the myocardium
 (duration) **3** yrs. mos. ds.

CONTRIBUTORY **Acute dilatation of the heart**
 (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **April 27, 31**

WAS THERE AN AUTOPSY? **yes**
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **D. S. Leoni,** M. B.
 , 19 (Address) **Barnard Hospital**

*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 **New Albany, Ind.**
 DATE OF BURIAL **May 5th, 31**

20. UNDERTAKER **George Hayes**
 ADDRESS **3214. Laclede**

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.

