

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

Do not use this space.  
**19332**

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. ....

Registered No. **5273**

St. .... Ward)

**2. FULL NAME** *Lizzie Brown*

(a) Residence. No. **001314 So. 10th St. 22** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **3** 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)

*widowed*

(a) IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) *March 24-1875*

**7. AGE**

YEARS

MONTHS

DAYS

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

*56*

*1*

*7*

**8. OCCUPATION OF DECEASED**

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

*Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

*235*

(c) Name of employer

**9. BIRTHPLACE** (CITY OR TOWN)

(STATE OR COUNTRY) *Mo.*

**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. Hospital Information**

INFORMANT *Grace Brown*

(Address) *City Hospital*

**15.**

FILED *1933*

19

REGISTRAR *W. H. Starks*

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) *May 1st 1931*

**17.**

I HEREBY CERTIFY, That I attended deceased from *April 5th*, 19*31*, to *May 1st*, 19*31*, that I last saw her alive on *May 1st*, 19*31*, and that death occurred, on the date stated above, at *11:55 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic myocarditis*  
*930*  
(duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) *930*  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**19. DID AN OPERATION PRECEDE DEATH?** *no* DATE OF *no*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical + laboratory*

(Signed) *W. E. Scherman*, M. D.

*571*, 19*31* (Address) *City 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**

DATE OF BURIAL

*St. Mathew*

*5/4 1931*

**20. UNDERTAKER**

ADDRESS

*W. M. McLaughlin*

*1631 MO*

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.

