

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

Do not use this space.

19527

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1005**

City.....

St. Louis (No. 5028 Emerson)

File No.....

Registered No. **5484**

St.....

Ward.....

2. FULL NAME

(a) Residence No. **5028 Emerson** St. **7** Ward.

(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) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Edward Smith*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1-29-1895*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *56 3 10*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Housewife 2³⁵* (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) *Hamburg, Mo*

10. NAME OF FATHER *John Pabel*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Hamburg, Mo*

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT (Address) *Luke Smith 5028 Emerson*

15. FILED *May 11 1931* REGISTRAR *W. C. Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 9 1931*

17. I HEREBY CERTIFY, That I attended deceased from *May 2 1931*, to *May 9 1931*, that I last saw her alive on *May 4 1931*, and that death occurred, on the date stated above, at *4:30 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: *Acute dilatation heart*

CONTRIBUTORY (SECONDARY) *Chronic myocarditis - multiformed origin* (duration) *1* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? (IF NOT AT PLACE OF DEATH) *Home*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *W. E. Owen* M. D. *3711 1931* (Address) *University Club Bldg.*

*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* DATE OF BURIAL *May 12 1931*

20. UNDERTAKER *J. J. Quinn* ADDRESS *1522 Federal Bldg.*

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.

