

**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

File No. **19889**

Township.....

Primary Registration District No.

Registered No. **5914**

City.....

(No. **ISOLATION HOSPITAL**)

St. Ward)

2. FULL NAME

Maudie E. Lehman

(a) Residence No. **1445 Hedlamont St 6** 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)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Aug 16 1903

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>27</i>	<i>9</i>	<i>7</i>	

8. OCCUPATION OF DECEASED

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

Nurse - 1st

(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)

Ill.

PARENTS

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)

? Amphur
Leffler

14. INFORMANT

(Address)

Joe Leffler
ISOLATION HOSPITAL

15. FILED

MAY 25 1931

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 23 1931

17.

I HEREBY CERTIFY, That I attended deceased from

Jan 22, 1931, to May 23, 1931
that I last saw her alive on *May 23, 1931* and that death occurred, on the date stated above, at *7:45 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs

(duration) *1* yrs. *3* mos. ds.

CONTRIBUTORY *Tuberculosis of Bowels*
(SECONDARY)

(duration) *5* mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH.....?

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Bacilli in Sputum*

(Signed) *Thomas J. Ulrich*, M. D.

3-24-1931 **ISOLATION 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

Oak Hill Cemetery

May 26 1931

20. UNDERTAKER

ADDRESS

Louis H. Bopp

Kerkewood Mo.

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.

