

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

Do not use this space.

✓ 22850
File No. _____
Registered No. **6278**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **6278**
City **St. Louis, Mo.** (No. _____) Sanitarium _____

2. FULL NAME

Julia Cornelius
(a) Residence No. **1805^a Bernard** St., **13** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **88 yrs. 11 mos. 3 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**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 2, 1842**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 11 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Unknown**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER **Unknown**

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 **Herbert P. Smith**
(Address) **5400 Casswell St.**

15. FILED **1931** **Miss C. Stanley**
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 4 1931**
17. _____

I HEREBY CERTIFY, That I attended deceased from **July 1st 1930** to **June 4, 1931**
that I last saw her alive on **June 3, 1931**, and that death occurred, on the date stated above, at **3:30 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
9:30
10:2

(duration) **1⁺** yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) **Senility**
(duration) **1⁺** yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED **Unknown**
NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **clinical**
(Signed) **Herbert P. Smith, M.D.**
6/8 1931 (Address) **5400 Casswell St.**

*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 **June 5, 1931**

20. UNDERTAKER **Nargain Sheahan** ADDRESS **Washington**

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.

WHITE PAPER WITH UNFADING INK—THIS IS A PERMANENT RECORD

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