

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

Do not use this space.

26720

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No. 791)

Registration District No. 791
Primary Registration District No. 1003
ISOLATION HOSPITAL

File No.
Registered No. 7911
St. Ward)

2. FULL NAME

Nellie A. Wideman
(a) Residence. No. 7712 Lovell St. 13 Ward. St. Louis Co. Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 12 yrs. 7 mos. 2 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 Grant A. Wideman
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 14, 1900
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 31 0 1
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Housewife
(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) Missouri
10. NAME OF FATHER George Ware
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Martha Gendron
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Leona Burns
(Address) ISOLATION HOSPITAL

15. FILED 10 19 31 W. C. Standley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15 1931
17. I HEREBY CERTIFY, That I attended deceased from 7 11 1931 to 7 15 1931 that I last saw her alive on 7 15 1931, and that death occurred, on the date stated above, at 9 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108 Pt 108
1513
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Erysipelas of Face
non-traumatic cause unknown
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Asper. Ind. Actin.
John Eschenbrenner M.D.
(Signed) 7/16/31 (Address) 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 St. Clair Mo
DATE OF BURIAL 7, 18 31

20. UNDERTAKER Casey Und.
ADDRESS St. Clair 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.

