

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

Do not use this space.

29485

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 5411, Easton Ave. St. 6 Ward)

File No. _____
 Registered No. 8506

2. FULL NAME Ida Minnie Rose
 (a) Residence No. 5411 Easton Ave. St. 6 Ward.
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4, 1910
7. AGE
 YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 0 3
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Office Girl 35 1/2
 (b) General nature of industry, business, or establishment in which employed (or employer) 1297
 (c) Name of employer 1297

9. BIRTHPLACE (CITY OR TOWN) Washington Co
 (STATE OR COUNTRY) Missouri
10. NAME OF FATHER Don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
 (STATE OR COUNTRY) Don't know
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ?
 (STATE OR COUNTRY) Don't know

14. INFORMANT Dr. Rose Minnie Rose
 (Address) 5411 Easton Ave
15. FILED 266-6-13 W. C. Standen
 19 1931 REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1931
17. I HEREBY CERTIFY, that I attended deceased from 7/10 1931, to 8/4 1931, that I last saw her alive on 7/31 1931, and that death occurred, on the date stated above, at 11.09 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sepsis due to bacterial suppurative
Parotitis Pleuritis
Brain abscess, diplococcus capsulatus
Wagoner (duration) yrs. 3 mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? yes DATE OF 7/11/31
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) W. C. Standen M. D.
8/5 1931 (Address) St. Louis Mo

*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 Valhalla Cemetery DATE OF BURIAL 8-6 1931
20. UNDERTAKER Geo. L. Pleitsch Inc ADDRESS 5966 Easton Ave

PARENTS

Oct. 1847

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....
 Township..... Primary Registration District No. 1883 Registered No. 8306
 City St. Louis (No.) St. Ward)

2. FULL NAME

Ira Minnie Rose

(a) Residence. No. St. Ward. (If nonresident give city or town and State)
 (Usual place of abode)

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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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)

PARENTS

14. INFORMANT (Address)

15. FILED 1-3-19 Wm. C. Starnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 19 31

17. I HEREBY CERTIFY, That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS: ' Salpingitis bilateral
suppurative peritonitis
placental Gran. Neg.
Staphylococcus infection
 CONTRIBUTORY Vaginal origin
"Staphylococcus" Salpingitis Subacute
given over phone by Dr. H. B. Kerrick

18. WHERE WAS DISEASE CONTRACTED Div. of U.S. 10-7-31
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) 55..... M. D.
 , 19..... (Address)

*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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-29485