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.

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

Do not use this space.

36381

1. PLACE OF DEATH

County ..... Registration District No. 731

Township ..... Primary Registration District No. 10083

City St. Louis (No. City Hospital St. ..... Ward)

File No. .....

Registered No. 10918

6703

2. FULL NAME Nora Gable

(a) Residence, No. 5094 Minerva St. Ward. 6
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6 - 1889

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
42	1	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER

15. MAIDEN NAME Unknown.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Hospital Information Grace Kopp City Hospital

18. BURIAL, CREMATION, OR REMOVAL St. Peter's Kirkwood Mo. DATE Oct 30 1931

19. UNDERTAKER (ADDRESS) J H Sharkey 4355 Washington

20. FILED OCT 29 1931 19 Ward Stanley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 27th. 1931

22. I HEREBY CERTIFY, That I attended deceased from July 16th 1931, to Oct. 27th, 1931

I last saw her alive on Oct. 27th, 1931. Death is said to have occurred on the date stated above, at 8.25 a.m.

The principal cause of death and related causes of importance were as follows:

Acute Pulmonary tuberculosis (tuberculous bronchi pneumonia)

23A

Other contributory causes of importance: 23

Date of onset

Name of operation ..... Date of .....

What test confirmed diagnosis? clinical laboratory Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) F M Macnish, M. D.

(Address) City Hosp II

Gable –

Sharkey