

**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**

Township

Primary Registration District No. **1003**

City *St. Louis Mo.* (No.) *General Hospital*

File No. **39503**

Registered No. **11693**

2. FULL NAME

(a) Residence, No. *3640 Shaw Ave S 17* Ward.

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) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 5 1872*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *59 9 17*

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. *at home*
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 Mo*

13. NAME *Jan known Fitcher*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Jan known*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Fran Helen Johnson 3640 Shaw Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Bellefontaine Cem* DATE *11-24* 19*31*

19. UNDERTAKER (ADDRESS) *33rd St 1945th Ward Blvd*

20. FILED *Nov 23 1931* Registrar *Wm C Farley*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11-22*, 19*31*

22. I HEREBY CERTIFY, That I attended deceased from *11-10*, 19*31*, to *11-22*, 19*31*

I last saw him alive on *11-22*, 19*31*. Death is said to have occurred on the date stated above, at *2:50* p.m.

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

Subdural Hemorrhage
87A
Other contributory causes of importance: *Tie Dolorous* *1 yr*

Name of operation *Posterior Ronsctomy* Date of *11-23-31*
What test confirmed diagnosis? *autopsy* 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? *no*
If so, specify
(Signed) *[Signature]*, M. D.
(Address) *400 Metropolitan Bldg*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

