

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

Do not use this space.

6203

1. PLACE OF DEATH

County Registration District No. **791**
 Township Primary Registration District No. **1003**
 City **St. Louis Mo** (No. **ISOLATION HOSPITAL**) St. Ward
 Registered No. **1230**

2. FULL NAME

(a) Residence, No. **3. Kingside** St. **12** Ward. **Shinloch Park Mo**
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **1** yrs. **7** mos. **5** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE Colored	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 10 1930		
7. AGE	YEARS 2	MONTHS 0
	DAYS 25	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	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) Mo		
FATHER	13. NAME Lambert Lewis	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo	
MOTHER	15. MAIDEN NAME Webb	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo	
17. INFORMATION (ADDRESS) ISOLATION HOSPITAL		
18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Place DATE 2/6 19 32		
19. UNDERTAKER (ADDRESS) W. S. Wade and Co.		
20. FILED FEB - 5 1932 W. S. Wade Registrar.		

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb 4 1932**

22. I HEREBY CERTIFY, That I attended deceased from **Feb 3 1932** to **Feb 4 1932**
 I last saw him alive on **Feb 4 1932** Death is said to have occurred on the date stated above, at **2:30** p.m.
 The principal cause of death and related causes of importance were as follows:
Scarlet Fever Date of onset **1-28**
1074
 Other contributory causes of importance:
Bronchopneumonia **2-3**
Secondary
 Name of operation **None** Date of
 What test confirmed diagnosis? **Abundant Coccidial bodies** Was there an autopsy? **Yes**
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **No** 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: **None**
 (Signed) **John Eschenbrenner** M. D.
 (Address) **ISOLATION HOSPITAL**

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.

THIS IS A PERMANENT RECORD

