

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

Do not use this space.

14846

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. *701*  
Primary Registration District No. *1003*  
(No. *Salvation Army Hosp.*)

File No.....  
Registered No. *4245*  
St..... Ward.....

**2. FULL NAME**

*Shirley Jean Little*

(a) Residence, No. *5736 Delmas Ave.* St. *12* Ward.....  
(Usual place of abode)

(If nonresident, give city or town and State)

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

*Female* *White* *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 28, 1932*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*0* *0* *1*

**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) *St. Louis*  
(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Elizabeth Little*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Dequain*  
(STATE OR COUNTRY) *Illinois*

14. INFORMANT *Allen L. Benson*  
(Address) *3740 Marquette*

15. FILED *MAY -1, 1932* *Wm. C. Harkley*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 29* 19*32*

17. I HEREBY CERTIFY, That I attended deceased from *4-28* 19*32*, to *4-29* 19*32* that I last saw her alive on *April 29* 19*32*, and that death occurred, on the date stated above, at *11:30 a.m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*159* *Prematurity*

(duration) yrs. mos. / ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Way Deutch* M. D.

, 19 (Address) *Salvation Army Hosp.*

\*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

*St. Trinity Lutheran Cem.* *5/2* 19*32*

20. UNDERTAKER

*C. Hoffmeister & Co.* ADDRESS *7844 S. Broadway*

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.

