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.

21533

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 6101

Township ..... Primary Registration District No. 1005 Registered No. 6101

City St. Louis (No. 500 S. Kingshighway St. Louis Childrens Hosp St. ..... Ward)

2. FULL NAME Jean Marie Colombo

(a) Residence, No. 2 St., 12 Ward. West Frankfort, Ill
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 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) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-20-32

7. AGE YEARS MONTHS 4 DAYS 10 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

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) West Frankfort Ill

FATHER

13. NAME J. P. Colombo

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

MOTHER

15. MAIDEN NAME Rose Barra

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cala City, Ill

17. INFORMANT (ADDRESS) J. McIlven 500 S. Kingshighway

18. BURIAL, CREMATION, OR REMOVAL PLACE West Frankfort Ill DATE 7-2 1932

19. UNDERTAKER (ADDRESS) Otis Stone West Frankfort Ill

20. FILED JUN 30 1932 19 Max C. Starkey Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-30-32, 19

22. I HEREBY CERTIFY, That I attended deceased from 5-22-32, 19, to 6-30-32, 19

I last saw her alive on 6-30-32, 19 Death is said to have occurred on the date stated above, at 3:30 A.m.

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

	Date of onset
Hydrocephalus	4/x/32
157A Communicating	
Non-Tuberculous	

Other contributory causes of importance: 15701

Name of operation Choroid Plexectomy Date of 6/28/32

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?

If so, specify

(Signed) Lawrence Goldman, M. D.

(Address) St. Louis Childrens Hosp