

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

Do not use this space.

24927

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No.
Primary Registration District No.

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence, No. St., 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abt. 63 - -

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) *St Louis mo 1*

13. NAME *Louisa Lunceon*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown 910*

15. MAIDEN NAME *unknown*

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

17. INFORMANT (ADDRESS) *A Gertrude Leach City Hospital # 2*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *Washington Park Aug 1 1932*

19. UNDERTAKER (ADDRESS) *J. A. Green 9915 Franklin Ave*

20. FILED *1116-1 1932* Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-23-1932*

22. I HEREBY CERTIFY, That I attended deceased from *7-18*, 19*32*, to *7-23*, 19*32*. I last saw him alive on *7-23, 30*, 19*32*. Death is said to have occurred on the date stated above, at *12 m.*

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

*930
97
Chronic myocarditis
Arteriosclerosis*

Other contributory causes of importance: *730*

Name of operation..... Date of.....
What test confirmed diagnosis..... Was there an autopsy? *no*

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) *Am Smith*, M. D.
(Address) *C. T. Y. HOSP. No. 2*

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.

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