

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

Do not use this space.

27288

**1. PLACE OF DEATH**

96 County St. Louis County. Registration District No. 790  
2 Township Central Primary Registration District No. 6033  
7 City Clayton (No. St. Louis County Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME** Margurite Irvin

(a) Residence, No. 9917 Lark St. \_\_\_\_\_ Ward. St. Louis County, Mo.  
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 27, 1908  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
24 -- 16  
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. 235  
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) Arkansas 2

13. NAME James Friend

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

15. MAIDEN NAME Ora Stanley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 31

17. INFORMANT (ADDRESS) Thomas Irvin  
9917 Lark

18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Hope DATE Aug. 15, 1932

19. UNDERTAKER (ADDRESS) Douthern Hud Co  
6320 So Grand Ave

20. FILED Aug 13 1932 B. W. Sullivan  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 11, 1932

22. I HEREBY CERTIFY, That I attended deceased from July 2, 1932, to Aug 11, 1932.  
I last saw him/her alive on Aug 11, 1932. Death is said to have occurred on the date stated above, at 12:45 p.m.

The principal cause of death and related causes of importance were as follows:  
Death when free lance  
Drugs when in business  
Car accident  
Choking clothes  
exploded.

Other contributory causes of importance \_\_\_\_\_  
181  
James Friend  
St. Louis County  
57

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
(What test confirms 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? no  
If so, specify \_\_\_\_\_

(Signed) Samuel J. Field M.D.  
(Address) St. Louis Co. 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.

SEP 27 1932

RECORD WITH COMPILING THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis Registration District No. 790  
 Township \_\_\_\_\_ Primary Registration District No. 0033  
 City Clayton (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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE YEARS	MONTHS	DAYS
		If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	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)	

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED Aug 13 1932 Killip Sullivan Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 11 1932

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the \_\_\_\_\_ stated above, at \_\_\_\_\_ m.

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

Quinine when applied  
which she was  
wearing clothes  
applied

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) \_\_\_\_\_, M. D.  
 (Address) \_\_\_\_\_

**SUPPLEMENTARY**

N. B.—Every person should be carefully supplied. A. E. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-27288