

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

Do not use this space.

33653

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No. **EQ. 03**
City **St. Louis** (No. **4124** , **Gano ave.** St. Ward)

File No.....
Registered No. **8941**
St. Ward)

2. FULL NAME **Harriett Storll.**

(a) Residence, No. St. **10** Ward.
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **August 6 1865**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 2

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. **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) **Florissant Mo. 1**

13. NAME **John Lattrace**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Florissant Mo.**

15. MAIDEN NAME **Harriett Weaver**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Florissant Mo.**

17. INFORMANT **Fred Storll** (ADDRESS) **4124 Gano**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Peters Cem.** DATE **Oct 10**, 19**32**

19. UNDERTAKER **D. M. Schumaker** (ADDRESS) **4834 National Bridge**

20. FILED **OCT -7 1932** **Max C. Stuckloff** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 6 1932**

22. I HEREBY CERTIFY, That I attended deceased from **Oct 20** to **Oct 6 1932**
I last saw him alive on **Oct 6 1932** Death is said to have occurred on the date stated above, at **11:00** a.m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Bronchitis Chronic
Date of onset

Name of operation **no** 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? **no**
If so, specify.....
(Signed) **D. M. Schumaker**, M. D.
(Address) **1537 Broadway**

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.

