

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

Do not use this space.

33851

1. PLACE OF DEATH

County..... Registration District No. 791 File No.
 Township St. Louis Mo Primary Registration District No. 1003 Registered No. 9151
 City St. Louis Mo (No. St. Johns Hospital Ward)

2. FULL NAME

(a) Residence. No. 6222 1/2 Arsenal St. 3 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 9 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>68</u>	<u>8</u>	<u>4</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
 (b) General nature of industry, business, or establishment in which employed (or employer) 235
 (c) Name of employer At Home

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England &

10. NAME OF FATHER Unknown Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) 31

12. MAIDEN NAME OF MOTHER Green

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) 31

14. INFORMANT Mabel Ray
 (Address) 6222 1/2 Arsenal St.

15. FILED OCT 15 1932 Max C. Starkloff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1932

17. I HEREBY CERTIFY, That I attended deceased from 10/13/32 to 10/13/32, 19...
 that I last saw h. alive on 10/13/32 at 9:45 P.M., 19... and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis (chronic)
 (duration) yrs. 6 mos. da.

CONTRIBUTORY (SECONDARY) Coronary thrombosis
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) W. F. Hall, M. D.
 10/19/32 (Address) Summit Bldg

*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 St. Peter Cemetery DATE OF BURIAL Oct 17 1932

20. UNDERTAKER Wm. J. Robert ADDRESS 1905 1/2 Grand

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.

CONTINUING THIS IS A PERMANENT RECORD

