

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

Do not use this space.

34233

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. City Hospital #1)

File No.....
Registered No. 9593
St. Ward)

2. FULL NAME

(a) Residence, No. 7105 Olive Street St. 24 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>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Herron</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Unknown 1890</u>		
7. AGE YEARS <u>About 42</u>	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. <u>At home</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>235</u>	
	11. Total time (years) spent in this occupation	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Idaho

MOTHER FATHER 13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) John Herron 7105 Olive

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Ch. DATE Oct 29 1932

19. UNDERTAKER (ADDRESS) J. W. Gibbons & Co 8022 Midway

20. FILED OCT 29 1932 Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 26, 1932

22. I HEREBY CERTIFY, That I attended deceased from St. Louis, 1932, to St. Louis, 1932.

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 9:00 a.m.

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

108
76 Lobar Pneumonia
Chronic Morphism

Other contributory causes of importance:

108 (circled)
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..... No Injury
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) [Signature] M.D.

(Address) [Address]

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

