

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

Do not use this space.

42089

1. PLACE OF DEATH

County..... Registration District No. **701**
Township..... Primary Registration District No. **2**
City **St. Louis, Mo. City Hospital** Ward **2**

File No.....
Registered No. **11214**
St..... Ward)

2. FULL NAME

(a) Residence, No. **3517 Franklin** St. **21** 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 **Female** 4. COLOR OR RACE **Col** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) **Widowed**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **2-20-1871**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 9 23

OCCUPATION
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. **Hotel 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) **Tenn 2**

MOTHER FATHER
13. NAME **David Sanders**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Tenn**

15. MAIDEN NAME **Eliza Unknown**

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

17. INFORMANT **A Debrae Creath** (ADDRESS) **City & Hospital 2**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Greenwood** DATE **12/17/32**

19. UNDERTAKER **Wm. C. Mc Dowell** (ADDRESS) **25th St. Frankfort, Mo**

20. FILED **DEC 17 1932** Registrar.

1 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12-13-1932**

22. I HEREBY CERTIFY, That I attended deceased from **12-5-32** to **12-13-32**, 19**32**
I last saw **u** alive on **12-13-32**, 19**32** Death is said to have occurred on the date stated above, at **7:00** m.
The principal cause of death and related causes of importance were as follows:

936
Chronic Myocarditis
Other contributory causes of importance: **11 13 15**

Name of operation _____ Date of _____
What test confirmed diagnosis **Ch. Lab** Was there an autopsy? **2**

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. **(11)**

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) **Wm. C. Mc Dowell**, M. D.
(Address) **City Hospital 2**

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.

