

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

Do not use this space.

25175

1. PLACE OF DEATH

County Registration District No. **101**
 Township Primary Registration District No. **1006**
 City **St. Louis mo.** (No. **City Hospital # 2**) St. Ward)

File No.
 Registered No. **6599**

2. FULL NAME

Ethel Margrett
 (a) Residence, No. **15a** St. Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred **16** 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) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bessie Margrett		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-6-90		
7. AGE	YEARS	MONTHS
	30	2
		DAYS
		19
		If LESS than 1 day, hrs. or min.
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.	
	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) Ma		
MOTHER	13. NAME John Jackson	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ma	
	15. MAIDEN NAME Catherine Mary	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ma	
17. INFORMANT A. Gustafson (ADDRESS) City Hospital		
18. BURIAL, CREMATION, OR REMOVAL PLACE Wentworth DATE 8-4 19 33		
19. UNDERTAKER Beard (ADDRESS) 4219 W. Center		
20. FILED JUL 31 1933 J. F. Bredeck Registrar.		

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-25** 19**33**

2. I HEREBY CERTIFY, That I attended deceased from **4-19** 19**33** to **7-25** 19**33**
 I last saw him alive on **7-25** 19**33** Death is said to have occurred on the date stated above, at **8:00** m.
 The principal cause of death and related causes of importance were as follows:
931 Pulmonary Tuberculosis
 Other contributory causes of importance:
 Name of operation Date of
 What test confirmed diagnosis? **Spinal fluid** 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?
 If so, specify **Pulmonary Tuberculosis**
 (Signed) **P. Smith** 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.

AUG 25 1933

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