

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

Do not use this space

29561

**1. PLACE OF DEATH**

County Jackson  
Township Bay  
City St. Louis, Mo.

Registration District No. 399  
Primary Registration District No. 1002  
(No. General Hospital #2)

File No. \_\_\_\_\_  
Registered No. 3892  
St. 3 Ward)

**2. FULL NAME**

(a) Residence, No. 1100 Basin St., \_\_\_\_\_ Ward.

(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>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Unknown</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>5-2-1883</u>		
7. AGE	YEARS	MONTHS
	<u>50</u>	<u>4</u>
		<u>21</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>House work</u>		11. Total time (years) spent in this occupation _____
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky.</u>		
13. NAME <u>Unknown</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>Record Desk</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE (City, State, and Country) DATE <u>50-29-1933</u>		
19. UNDERTAKER (ADDRESS) <u>Julius W. Fillingim</u>		
20. FILED <u>7/10/33</u> 19 <u>33</u> in <u>St. Louis</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-23-1933

22. I HEREBY CERTIFY, That I attended deceased from 9-21, 1933 to 9-23, 1933  
I last saw him alive on 9-23, 1933 Death is said to have occurred on the date stated above, at 7:50 P.M.  
The principal cause of death and related causes of importance were as follows:  
Acute Hemorrhagic Gastro-Enteritis  
Acute Fibrinous Peritonitis  
Other contributory causes of importance:  
Shock from Hemorrhage

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

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) J. O. Dwyer M.D.  
(Address) General Hospital #2

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.

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