

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

Do not use this space.

38521

**1. PLACE OF DEATH**

County St. Louis mo Registration District No. City, Hospital # 2  
Township City, Hospital # 2 Primary Registration District No. City, Hospital # 2  
City St. Louis mo (No. City, Hospital # 2)

File No. \_\_\_\_\_  
Registered No. 10185  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 2949 EASTON St. 21 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 9 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX FEM. 4. COLOR OR RACE C. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-15-1909

7. AGE YEARS 24 MONTHS 1 DAYS 3 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. HOUSEWORK

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) MO

13. NAME FRED TAYLOR

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

15. MAIDEN NAME BELLE MURPHY

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

17. INFORMANT BELLE TAYLOR

18. BURIAL, CREMATION, OR REMOVAL PLACE Herculaneum DATE 11-25-38

19. UNDERTAKER Wm F. Barnhart

(ADDRESS) Crystal City, Mo

20. FILED J. F. Beck Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-25-1938

22. I HEREBY CERTIFY, That I attended deceased from 10-23-1938, to 11-25-1938

I last saw her alive on 11-25-1938 Death is said to have occurred on the date stated above, at 8:45 m.

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

TOXIC GOITRE 2 MO  
UNICHOXIN  
Date of onset \_\_\_\_\_

Name of operation PARTIAL THYROIDECTOMY Date of operation \_\_\_\_\_  
What test confirmed diagnosis? OPERATION Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? NO 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 Henry E. Hampton, M. D.  
(Signed) \_\_\_\_\_ (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

JAN 9 1939

