

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.

MAR 24 1934

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

Do not use this space.

3468-*9*
21

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis, Mo.* (No.....)

ISOLATION HOSPITAL

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *1167*
St. Ward)

2. FULL NAME

Ellen Mae Byers
(a) Residence, No. *1820 S. Wharf St.* *23* Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *3 yrs. 4 mos. 27 ds.* How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>female</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>single</i>
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Sept 2, 1930</i>		
7. AGE	YEARS <i>3</i>	MONTHS <i>4</i>
	DAYS <i>27</i>	If LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	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) *St. Louis*
(STATE OR COUNTRY) *Missouri*

MOTHER FATHER
13. NAME *Raymond Byers*

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

15. MAIDEN NAME *Leona Arthur*

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

17. INFORMANT *Leona Burne*
(ADDRESS) *2600 Arsenal*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *City Cemetery* DATE *Jan 31 1934*

19. UNDERTAKER *Mrs. G. Scheckbauer*
(ADDRESS) *3000 Olive St.*

20. FILED *FEB - 1 1934*
J. J. Bredekamp
Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 30 1934*
2. I HEREBY CERTIFY That I attended deceased from *Jan 24 1934* to *Jan 30 1934*
I last saw him alive on *Jan 30 1934* Death is said to have occurred on the date stated above, at *4:30 p.m.*

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

Measles Date of onset *1-22*
Bronchopneumonia *10-29*
Otitis Media Bilateral *8-12*

Other contributory causes of importance

Name of operation *None* Date of *None*
What test confirmed diagnosis? *Clinical* 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? *No*
(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 *No*
(Signed) *Oliver Schenkman* M. D.
(Address) *ISOLATION HOSPITAL*

