

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.

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. **791**  
Township ..... Primary Registration District No. **1003**  
City *St. Louis Mo* No. *St Annis Hosp*

File No. **6468**  
Registered No. **1306**  
St. .... Ward

2. FULL NAME

*Mrs Gerda Young*  
(a) Residence, No. *Sampson Mo* St. *NR* Ward. *Sampson Mo*  
(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 *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Divorced*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Divorced*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*abt 20*

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) *Mo*

MOTHER FATHER 13. NAME *Sylvester Gill*

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

15. MAIDEN NAME

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

17. INFORMANT *Sister Bernique*  
(ADDRESS) *5301 Page Ave*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Manqua Mo* DATE *2-4* 1934

19. UNDERTAKER *M Mahan Funeral Service*  
(ADDRESS) *Madisonville Mo*

20. FILED *FFB - 5 1434* *JF Bredeck*  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 3* 1934  
22. I HEREBY CERTIFY, That I attended deceased from *Dec. 4*, 1933, to *Feb. 2*, 1934.  
I last saw her alive on *Feb 2*, 1934 Death is said to have occurred on the date stated above, at *7:10* a.m.  
The principal cause of death and related causes of importance were as follows:

Date of onset  
*Peritonitis*  
*Obstetrical shock*  
*104*  
Other contributory causes of importance  
*Prolonged labor due to Bachel Rupture of uterus*

Name of operation ..... Date of .....  
What test confirmed diagnosis? *Routine*. 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 .....  
(Signed) *John B. O'Neil* M. D.  
(Address) *330 Miss. Club Bldg*

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