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 File No. 7040

Township ..... Primary Registration District No. 1003 Registered No. 1919

City St Louis (No. City Hosp #1 St. ..... Ward)

2. FULL NAME 19466 Agnes Scritchfield

(a) Residence, No. 5232 Blair St. 9 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Scritchfield

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 26 1884

7. AGE YEARS 49 MONTHS 7 DAYS 24 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

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) St Louis Mo

FATHER

13. NAME Unknown

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Hosp Inf M Kent City Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE Feb 26th 1934

19. UNDERTAKER (ADDRESS) Stroat & Carroll Und Co 4600 Natl Bridge Ave

20. FILED FEB 23 1934 J. P. Bredick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/20, 1934

22. I HEREBY CERTIFY, That I attended deceased from 2/20, 1934, to 2/20, 1934

I last saw her alive on 2/20, 1934. Death is said to have occurred on the date stated above, at 11 03 p.m.

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

Lobar Pneumonia Lt.

108 110A

108

Date of onset

Other contributory causes of importance: Empyema Lt Chest

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? .....

If so, specify .....

(Signed) [signature] M. D.

(Address) City Hospital