

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.

APR 25 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 2nd* (No. *Operation Hosp*) St. Ward

File No. **11188**
Registered No. **3051**
St. Ward

2. FULL NAME

Catherine Spaw
(a) Residence, No. *1510 Wash* St. *28* Ward

(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 *colored* 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) *Jan 27, 1933*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>1</i>	<i>1*</i>	<i>24</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *nil*
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) *Monroeville*

13. NAME *Alapora Shair*

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

15. MAIDEN NAME *Lena Henderson*

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

17. INFORMANT *Lena Shair*
(ADDRESS) *1510 Wash St.*

18. BURIAL, CREMATION, OR REMOVAL, PLACE *St. Louis* DATE *3/28* 19*34*

19. UNDERTAKER *H. M. C. Green*
(ADDRESS) *3517 Basile Ave*

20. FILED *APR 21 1934* *J. Bredek* Registrar.

MEDICAL CERTIFICATE OF DEATH

3
21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 20*, 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 13*, 19*34*, to *Mar 20*, 19*34*
I last saw her alive on *Mar 20*, 19*34*. Death is said to have occurred on the date stated above, at *10:30* a.m.

The principal cause of death and related causes of importance were as follows:
Pertussis
Bronchopneumonia
Otitis Media, bilateral

Other contributory causes of importance:

Name of operation *None* Date of

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

Where did injury occur? *None* Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) *J. Bredek* M. D.
(Address) *INSULATION HOSPITAL*

