

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.

MAY 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
1008
Primary Registration District No. *St. Maternity Hospital*

File No. **14267**
3424
Registered No.
St. Ward)

2. FULL NAME

(a) Residence, No. *824 Sanders Pl* St. *W.P.* Ward. *Mill Springs 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) *single*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 8 1921*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *78*

8. Trade, profession, or particular kind of work done, as planner, 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) *St. Louis*

MOTHER 13. NAME *Paul Messbaum*

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

15. MAIDEN NAME *Clara Stevenson*

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

17. INFORMANT *Dr Paul Messbaum*
(ADDRESS) *824 Sanders Place Mill Springs Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mill Springs Mo* DATE *28/6* 1934

19. UNDERTAKER *A Ellis*
(ADDRESS) *524 Delmar*

20. FILED *J. J. Brebeck*
MAY 25 1934 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-5-34* 19
22. I HEREBY CERTIFY, That I attended deceased from *3-8-34* 19, to *4-5-34* 19.
I last saw her alive on *4-5* 19. Death is said to have occurred on the date stated above, at *10:30 am*.

The principal cause of death and related causes of importance were as follows:
Prematurity Since birth
159 129

Other contributory causes of importance:

Name of operation *no* Date of

What test confirmed diagnosis? Was there an autopsy?

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.

Number of injury

Nature of injury

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

(Signed) *Robert Roberts* M. D.

(Address) *718 Beaumont*

Med. Adv.

