

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.

St. Louis Maternity Hospital

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 Missouri*

Registration District No. **791**
Primary Registration District No. **1003**
(No. *St. Louis Maternity Hosp.*)

File No. **19017**
Registered No. **5669**
St. Ward)

2. FULL NAME

(a) Residence, No. *2403 Hadley Ave 26* Ward.

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. (If nonresident, give city or town and State)

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) *5-29-34*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *4*

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *None*
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, Missouri*

MOTHER FATHER
13. NAME *Frank Varnon*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Charles, Missouri*

MOTHER FATHER
15. MAIDEN NAME *Hattie Szynkowski*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Missouri*

17. INFORMANT *Reconde St. Louis Mat Hosp.*
(ADDRESS) *507 Exchange*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Calvary Cem* DATE *June 6 1934*

19. UNDERTAKER *J. J. Kuhnert & Co*
(ADDRESS) *7847 Menard Ave*

20. FILED *26 1934*
19 *J. J. Brebeck*
Registrar.

U MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 31*, 19*34*
22. I HEREBY CERTIFY, That I attended deceased from *May 27*, 19*34* to *May 31*, 19*34*
I last saw *her* alive on *May 31*, 19*34*. Death is said to have occurred on the date stated above, at *7:30 p.m.*
The principal cause of death and related causes of importance were as follows:

congenital
157E
157D / *157C*
Other contributory causes of importance:
congenital malformation of
kidney
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) *W. S. Serivier*, M. D.
(Address) *6308. Rensselaer*

