

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

Do not use this space.

19035

1. PLACE OF DEATH

County..... Registration District No. 791
 Township St Louis Primary Registration District No. City No 1003
 City St Louis (No. City No 1003) St. _____ Ward _____

File No. _____
 Registered No. 6245

2. FULL NAME

(a) Residence, No. 4730 Easton Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 2 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Separated

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 11 - 1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>46</u>	<u>5</u>	<u>7</u>	

8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc. Wwk.

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) Illinois

13. NAME Liley

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

15. MAIDEN NAME Sanford

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

17. INFORMANT Harvey M. Cooper (ADDRESS) City of St. Louis

18. BURIAL, CREMATION, OR REMOVAL PLACE City of St. Louis DATE 6-20-34

19. UNDERTAKER James W. Cooper (ADDRESS) City of St. Louis

20. FILED 2 19 34 Registrar. J. B. Steed

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18 1934

22. I HEREBY CERTIFY That I attended deceased from May 1 1934 to May 18 1934
 I last saw her alive on May 18 1934 Death is said to have occurred on the date stated above, at _____ m.

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

Chronic Cholecystitis
126
gall stones
17 7 15
 Other contributory causes of importance: 124

Name of operation Cholecystectomy 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) J. J. Sauer M. D.

(Address) City of St. Louis

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.

