

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

OCT 11 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** (No. **7124**, **Westside Ave.**)

34112
 File No.
 Registered No. **8887**
 St. Ward)

2. FULL NAME

(a) Residence, No. **7124 Westside St.** Ward. **9**
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred **24** yrs. mos. ds. How long in U. S., if of foreign birth? **50** yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Smith		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-24-1861		
7. AGE	YEARS 73	MONTHS 5
	DAYS 9	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home	
	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) Scotland		
FATHER	13. NAME Unknown	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland	
MOTHER	15. MAIDEN NAME Unknown	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland	
17. INFORMANT Mrs Elizabeth Dief (ADDRESS) 7124 Westside		
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Johns DATE 9-6-34 , 19 34		
19. UNDERTAKER W. A. Stock and Co (ADDRESS) 2117 E. Pershing Blvd		
20. FILED JCP - J 1934 W. Bredeck Registrar.		

2. MEDICAL CERTIFICATE OF DEATH

No physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 3 - 1934**

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at **9 P.M.**

The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy Date of onset **93C**

Other contributory causes of importance:
Chronic Myocarditis

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **no**

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) **Harold J. Shuf**, M. D.
 (Address) **914/34**

