

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

Do not use this space.

JAN 8 1935

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township _____ Primary Registration District No. _____
 City St. Louis (No. 2409 East 9th St.) St. _____ Ward _____

File No. 43129

Registered No. 5515

2. FULL NAME

(a) Residence, No. 2409 East 9th St. 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 Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-1-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
57 6 20

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) no Record

13. NAME no Record

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no Record

15. MAIDEN NAME no Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no Record

17. INFORMANT Frederick Massie

(ADDRESS) 17409 East 9th St.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Floral Dep DATE 12/24/34

19. UNDERTAKER Mrs. C. L. Gentry

(ADDRESS) 718 Brookline ave.

20. FILED 12.23.34 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-21-34

22. I HEREBY CERTIFY, That I attended deceased from Oct. 19, 19 34 Dec. 21, 19 34

I last saw h. or alive on Dec. 20, 19 34 Death is said to have occurred on the date stated above, at P.M.

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

Broncho pneumonia
(See Certificate (infection))
 Other contributory causes of importance: 1070

Name of operation _____ Date of _____

What test confirmed diagnosis? Clinical 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.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify Sharkey & Co M. D.

(Signed) _____ (Address) 1014 Blvd. Pict. Bldg.

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.

val. 05/54

2 pm