

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.

*Central Township*

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

Do not use this space.

JUL 27 1935

20929

1. PLACE OF DEATH

County *St. Louis* Registration District No. *788*  
 Township *Central* Primary Registration District No. *4871*  
 CH, *Manchester, Woodlawn* St. \_\_\_\_\_ Ward \_\_\_\_\_  
*(No. \_\_\_\_\_) St. Agnes Home*

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ 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 *F.* 4. COLOR OR RACE *W.* 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) *Feb. 27, 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*70 4 2*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housework*  
 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) *Briggsville, Ill.*

13. NAME *Hasten Wells*

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

15. MAIDEN NAME *Julia Cumming*

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

17. INFORMANT (ADDRESS) *Mrs. Geo. S. Thomas Embassy Hotel, New York City*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Bellafontaine* DATE *7-1-1935*

19. UNDERTAKER (ADDRESS) *Bensick-Niehans Co 1138 - St. Louis*

20. FILED *6-30-1935* *Julia R. York* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-29* 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *6-7-* 19*35*, to *6-25-* 19*35*

I last saw her alive on *6-25-* 19*35* Death is said to have occurred on the date stated above, at *12:30 A.M.*

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

*Cardiac Asthma acd. De compensation yrs.*

Other contributory causes of importance \_\_\_\_\_

Name of operation *None* 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.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

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

(Signed) *W. O. Hayhurst* M. D.  
 (Address) *671 East Big Bend Webster Grover*

