

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

Do not use this space.

SEP 16 1935

27678

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. 2) Union Desloge File No.....
St. Ward) Registered No. 6722

2. FULL NAME

(a) Residence, No. 3537 Nemaska St., 17 Ward. (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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 5, 1935

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

22. I HEREBY CERTIFY, That I attended deceased from 7/23, 1935, to 8/15, 1935

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 11 1881

I last saw h.c.r. alive on Aug 5, 1935 Death is said to have occurred on the date stated above, at 7:30 p.m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 53 9 26

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

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

Carcinoma - metastatic - from Breast, to all viscera and brain
50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

Other contributory causes of importance:

13. NAME Michael Waugles

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? yes

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....

15. MAIDEN NAME Marriett Mahan

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K.S.

17. INFORMANT Hazel Hanagan (ADDRESS) 3537 Nemaska

Manner of injury.....
Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL PLACE next to father DATE Aug 8, 1935

19. UNDERTAKER Thos J. Funnell (ADDRESS) 1519 S Grand

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

FILED 9/16 - 7, 1935, 19. J. F. Bredeck Registrar.

(Signed) G. C. Brown M. D.
(Address) Farmers Desloge Hospital
1325 Grand

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DR. GORONWY O. BROUN

ST. LOUIS UNIVERSITY HOSPITALS
ST. MARY'S HOSPITAL GROUP
FIRMIN DESLOGE HOSPITAL
1325 SOUTH GRAND BOULEVARD
ST. LOUIS, MISSOURI

August 8, 1935

Director,
Bureau of Vital Statistics,
City Hall,
St. Louis, Missouri.

Dear Sir:

I wish to make a supplementary report regarding the death of Alvina Minnie Knight of 3537 Henrietta Avenue. The death certificate which I filled out recorded the cause of death as Carcinoma of the breast with Metastases to Lungs, Brain, Liver and Kidneys. This diagnosis was confirmed by a complete post-mortem examination including an examination of the brain.

The relatives now wish to claim double indemnity for accidental death based on a fall which occurred at her home on July 8th, 1935. The patient became dizzy and fell down several steps suffering abrasions of the fore head and nose and a laceration of the third left index finger. She received treatment for these superficial injuries at Firmin Desloge Hospital on July 8th, 1935 at 7:35 P. M. We did not consider this injury as being significant in causing her death and found no evidences of skull fracture or gross cerebral hemorrhage at autopsy.

The patient remained ambulatory until July 19th, 1935. She entered the hospital July 23rd, 1935 showing some weakness of the muscles of the left side of the body; a condition that had been present to a slight degree since July 9th. Patient became delirious on July 26th with signs of complete left hemiplegia and died on August 5th at 2:38 P. M.

If there is any further information regarding this matter that I can give you I will be glad to do so.

Very truly yours,

G. O. Broun M. D.

G. O. Broun, M. D.

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

**ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.**

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. **Firmin Desloge Hospital**)..... St. Ward)

File No.....
Registered No. **6722**

2. FULL NAME ALVINA MINNIE KNIGHT

(a) Residence, No. **3537 Henrietta** St., **17** **XX**
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **August 5, 1935**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Thos. Knight**

22. I HEREBY CERTIFY, That I attended deceased from **7/23/35** to **8/5/35**, 19**35**

I last saw h. s. alive on **7/24**, 19**35**. Death is said to have occurred on the **240 P.m.** above, at **240 P.m.**
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Carcinoma of Right Breast with Metastases to Lungs, Brain, Liver + Kidneys
Date of onset **Uncertain**

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

Other contributory causes of importance:
abrasion of forehead + nose 7/8/35
laceration of third left finger 7/8/35

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED **9-13-35** **J. J. Brederick** Registrar.

Name of operation **Autopsy** Date of **7/8/35**

What test confirmed diagnosis? **Autopsy** Was there an autopsy? **Yes**

23. If death was due to external cause (violence), fill in also the following:
Cause of death? **Accident** Date of injury **7/8/35**

Where did injury occur? **at patient's home**
3537 Henrietta St. Ph. S. city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
In home

Manner of injury **Fell down steps**
Nature of injury **abrasion of forehead + nose laceration 3rd left finger**

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify.....

(Signed) **G. D. Brown**, M. D.
(Address) **1325 S. Grand**

SUPPLEMENTARY