

WHILE PLAINLY, WITH OBTAINING INTEREST 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.

SEP 16 1935

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *Decones Hospital*)

Registration District No. **791**
Primary Registration District No. **1003**

File No. **28037**
Registered No. **7117**
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. *N.P.* Ward. *Golden Gate Secs*
(Usual place of abode)

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 *Female* 4. COLOR OR RACE *white* 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) *Sept-12-1909*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 11 10

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) *Golden Gate Secs.*

13. NAME *P. C. Barab*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mt. Erie Pa.*

15. MAIDEN NAME *Emma Smith*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mt. Erie Pa.*

17. INFORMANT (ADDRESS) *W. O. C. Barab, Osney, Ills.*

18. BURIAL, CREATION, OR REMOVAL PLACE *Osney, Ills.* DATE *Aug 25 1935*

19. UNDERTAKER (ADDRESS) *Albert H. Nappert, 429 N. Audubon*

20. FILED *AUG 22 1935* 19. *J. A. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug-22-1935*

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 _____ m.

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

Septicemia from Fract. of rt. Femur & humerus; hemorrhage of brain, rec'd when deceased jumped from window of Decones Hosp. while suffering temporary mental disturbance

Other contributory causes of importance: *Suicide*

Name of operation..... 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 *Sept. 1, 1935*

Where did injury occur? *Osney, Ills.* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. *Decones Hospital*

Manner of injury *Fall*
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify _____
(Signed) *Harold G. Deffen* M. D.
(Address) *Osney, Ills.*

