

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.

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

DEC 12 1935

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis Mo.** (No. **Barnes Hospital**) St. Ward

37905

File No.
Registered No. **9884**
St. Ward

2. FULL NAME **Mildred Madaline Vincent**

(a) Residence, No. St. **N.R.** Ward. **Springfield Ill.**
(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.
(If nonresident, give city or town and State)

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 **Single**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 29th 1916**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 3 26
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Student**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Data 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) **Springfield Ill.**

13. NAME **Dr. C. Vincent**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kirkville Ill.**

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Dr. C. Vincent**
(ADDRESS) **Springfield Ill.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Springfield Ill.** DATE **Nov. 28th 1935**

19. UNDERTAKER **Albert W. Hottel Sr.**
(ADDRESS) **429 N. Euclid Bldg.**

FILED **6** 1935 19 **J. F. Bredeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11 - 25 - 1935**

22. I HEREBY CERTIFY, That I attended deceased from **11 - 24 - 1935** to **11 - 25 - 1935**

I last saw him alive on **11 - 25 - 1935** Death is said to have occurred on the date stated above, at **1:50 a.m.**

The principal cause of death and related causes of importance were as follows:
Chr. bronchiectasis Date of onset

Other contributory causes of importance:
Circulatory collapse

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) **H. A. Alving** M. D.
(Address) **BARNES HOSPITAL**

Ellinger & King
Springfield, Ill.