

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

7. Do not use this space.

AUG 18 1936

28418

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp..... Primary Registration District No. **1003**
 City..... **St. Louis, Missouri** **City Hospital No. 1**

File No. **7181**
 Registered No.
 St. Ward)

2. FULL NAME

(a) Residence, No. **515 Rutger** St., **22** 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 **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) **Oct. 27, 1935**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	0	8	17	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **nil**

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) **St. Louis, Missouri**

13. NAME **Paul Crawford**

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

15. MAIDEN NAME **Minerva ?**

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

17. INFORMANT **Hosp. Info. M.H. Kent**
 (ADDRESS) **City Hospital No. 1**

18. BURIAL, CREMATION OR REMOVAL
 PLACE **St. Matthews** DATE **July 16th 1936**

19. UNDERTAKER **R. W. McLaughlin**
 (ADDRESS) **2801 LAZARUS AVE**

20. FILED **14 1936** 19 **J. T. Bredeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7/14/36** 19

22. I HEREBY CERTIFY, That I attended deceased from **7/12/36** to **7/14/36**

I last saw her alive on **7/14/36**, 19

Death is said to have occurred on the date stated above, at **9. A. O. M. A.**

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

Heart exhaustion Date of onset

Other contributory causes of importance:

acute bronchitis
dehydration

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..... 19

Where did injury occur? **No** (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) **R. T. Brostoff**, M. D.

(Address) **City Hospital**

