

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 15 1936

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. City Hospital No. 1)

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

32504

File No.
Registered No. **8331**
St. Ward)

B. 6820 Grace Quillo

2. FULL NAME Grace Quillo (a) Residence, No. 2011 Cass St., 20 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*) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 12, 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 7 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. hwk
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) Italy

FATHER 13. NAME Jess Jucktree

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

MOTHER 15. MAIDEN NAME Jennie Cannara

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

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE August 12

19. UNDERTAKER Central Und. Co. (ADDRESS) 1841 Cass Ave.

20. FILE AUG 11 1936 J. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/10/36 19

22. I HEREBY CERTIFY, That I attended deceased from 8/3/36, 19, to 8/10/36, 19. I last saw him/her alive on 8/10/36, 19. Death is said

to have occurred on the date stated above, at 4:02 p.m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of colon Date of onset

Other contributory causes of importance Hb

Name of operation Distal Hemostage Date of yes
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 yes, 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 yes
(Signed) Reg. Seiwolf, M. D.
(Address) City Hospital No. 1

