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.

DEC 3 1936

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

Do not use this space.

43139

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11716

City St. Louis (No. City Hospital No.1 St. ..... Ward)

B. 11694

2. FULL NAME Aimee Louvier

(a) Residence, No. 1420 Monroe St., 26 Ward. (If nonresident, give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 24, 1881

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
55	10	2	

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. at home

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) Red Budd Illinois

FATHER

13. NAME James Elliff

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

MOTHER

15. MAIDEN NAME Liza Travers

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

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

18. BURIAL, CREMATION, OR REMOVAL PLACE East St Louis, Ill. DATE Nov. 29 1936

19. UNDERTAKER (ADDRESS) Nell Walsh Barnes East St. Louis, Ill.

20. FILED NOV 27 1936 19 J F Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/26/36, 19

22. I HEREBY CERTIFY, That I attended deceased from 11/9/36, 19 to 11/26/36, 19

I last saw her alive on 11/26/36, 19 Death is said to have occurred on the date stated above, at 4.35 a m.

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

Degenerative heart disease

93C

Date of onset

Other contributory causes of importance:

Broncho-pneumonia

Ascites

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) Geo. J. Seibold, M. D.

(Address) City Hospital No.1