

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**

Do not use this space.

14404

**MAY 7 1937**

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **C.256**)

City Hospital No. **1**

File No.....

Registered No. **3900**

St. .... Ward)

**2. FULL NAME**

**Mina Denoyer**

(a) Residence, No. **510 N. Hurck**  
(Usual place of abode)

St. **1** Ward.

(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 **Jos Denoyer**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 1, 1884**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**52 11 9**

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

OCCUPATION

MOTHER FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Indiana**

13. NAME ? **UNKNOWN**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? **UNKNOWN**

15. MAIDEN NAME **Mattie Peterson**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? **UNKNOWN**

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

18. BURIAL, CREMATION, OR REMOVAL

PLACE **MT. HOPE CEM.** DATE **4-14** 1937

19. UNDERTAKER **C. HOFFMEISTER U. + L. Co.**  
(ADDRESS) **784 S BROADWAY**

20. FATHER **J. F. Bredeck**  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4/10/37** 19

22. I HEREBY CERTIFY, That I attended deceased from **4/6**, 19**37**, to **4/10**, 19**37**

I last saw him alive on **4/10**, 19**37** Death is said to have occurred on the date stated above, at **12:05** p. m.

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

**Cerebral Hemorrhage (at) with left hemiplegia**

Date of onset

Other contributory causes of importance:

**Essential Hypertension**

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) **Charles M. Jessico**, M. D.

(Address) **City**

**APR 13 1937**

