WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. 1717 Linden St.; 5 Ward)

Registration District No. 701 File No. 31179

Primary Registration District No. 1003 Registered No. 9156

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Unk.

6 DATE OF BIRTH Unknown (Month) (Day) (Year)

7 AGE abt 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housework

(b) General nature of industry business, or establishment in which employed (or employer) 131 42

9 BIRTHPLACE (City or town, State or foreign country) Unknown

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Dever

(Address) Coroners Office

15 Filed OCT 6 1918, 19.. Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 23rd (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Was found dead

that I last saw h..... alive on ..... 191..

..... occurred, on the date stated above, at 1 P. m.

and that death ..

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

N.K.A. 79

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Dever M. D.

10/4, 1918 (Address) Dep Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence Unknown

19 PLACE OF BURIAL OR REMOVAL Greenwood Sd

DATE OF BURIAL 10/4, 1918

20 UNDERTAKER Gates-Manuel

ADDRESS 4107 Finney

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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