LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

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. 2810 S. 8 St.; 10 Ward)

Registration District No. 791 File No. 36128

Primary Registration District No. 1003 Registered No. 9495

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

2 FULL NAME Agnes M. Watsek

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan. 18, 1893 (Month) (Day) (Year)

7 AGE 25 yrs. 8 mos. 23 ds.

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

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

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

PARENTS

10 NAME OF FATHER Joseph Watsek

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

12 MAIDEN NAME OF MOTHER Catherine ~~Watsek~~ Dolezal

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Catherine Watsek
(Address) 2810 S. 8 St

15 Filed OCT 13 1918, 191..., Max C. Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 11 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from October 3rd, 1918, to October 11th, 1918, that I last saw her alive on October 11th, 1918, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) — yrs. — mos. 4 ds.

(Signed) Lawrence Thamer M. D.

October 12th, 1918. (Address) 1808 Victor St.

*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 SS Peter & Paul

DATE OF BURIAL Oct. 14, 1918

20 UNDERTAKER Wm C. Moydell

ADDRESS 1926 Allen

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... *or*

Village ..... *or*

City ..... (NO. ....., ... St., ... Ward)

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

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

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

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.