LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

File No. 33332

Registration District No. 781

Primary Registration District No. 1008

Registered No. 9764

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St. Louis (No. 1813a N. Newstead St.; No. ..... Ward)

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

2 FULL NAME Julia A. Wyche

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: May ? (Month) (Day) 1846 (Year)

7 AGE: 72 yrs. 6 mos. ? ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER: Jackson Emory

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): not known

12 MAIDEN NAME OF MOTHER: not known

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Miller
(Address) 1813a N. Newstead

15 Filed OCT 17 1913, 191.. Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 15 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10, 13, 1918 to 10, 15, 1918; that I last saw her alive on 10, 13, 1918; and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
92 H 79
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jay L. Perry M. D.
10, 16, 1918 (Address) 4482 Delmar

*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: Father Dickson

DATE OF BURIAL: 10/17 1918

20 UNDERTAKER: L. S. Williams

ADDRESS: 3232 Pine

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... or

Village ..... or

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

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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

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

[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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