

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

Do not use this space.

20354

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... # Primary Registration District No..... Registered No. 6202
City St. Louis (No. 4173) Botanical Ave St. Ward)

2. FULL NAME

(a) Residence. No. 4173 Botanical Ave. 2 St. Ward. 2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE; MARRIED; WIDOWED OR DIVORCED (write the word) Widowed
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5, 1873
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70. 6. 18. 0 0 0

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

9. BIRTHPLACE (CITY OR TOWN) Isla of Man
(STATE OR COUNTRY)

10. NAME OF FATHER Wm Doyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) England.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Jane (unknown)
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England.
(STATE OR COUNTRY)

14. INFORMANT Mrs Laura O Berty
(Address) #4173 Botanical Ave.

15. FILED Max B Starckoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23rd 1923.
17. I HEREBY CERTIFY That I attended deceased from April 28, 1923 to June 23, 1923 (that I last saw him alive on June 23, 1923, and that death occurred, on the date stated above, at 11:30 a.m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A (duration) 3 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF.....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Crem Spitzer
(Signed) Carl Spitzer, M.D.
, 19 (Address) 810-11 Independence Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bellefontaine DATE OF BURIAL June 26th 1923.

20. UNDERTAKER C. R. Lupton ADDRESS 4449 Olive St.

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.

