

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

Do not use this space.

2706

1. PLACE OF DEATH

County.....

Registration District No. 751

Township.....

Primary Registration District No. 003

City St. Louis (No. City Hospital)

File No.

Registered No. 273

St. Ward

2. FULL NAME

(a) Residence. No. 617 Skank St. 18 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

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

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 13 - 1874

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>52</u>	<u>9</u>	<u>24</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salace Worker
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

10. NAME OF FATHER

Edw. Duble

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Maggie Minion

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

14.

INFORMANT

(Address) City Hospital

15.

JAN - 8 1927 FILED Max B. Starnes REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 6 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 2, 1927 to Jan 6, 1927 that I last saw him alive on Jan 6, 1927 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
None
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Did an operation precede death?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? Skincod

(Signed) Robert M. Smith, M. D.

(Address) City Hospital

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Calvary Cemetery Jan 8 1927

20. UNDERTAKER

ADDRESS

Kriegshauser and Co Manchester

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.

Pitts