

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

Do not use this space.

13298

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo.** No. **1437 - Blinton St** (Ward)

File No.
 Registered No. **3612**

2. FULL NAME

(a) Residence. No. **1437 - Blinton St.** **26** Ward.

(Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Dec 5 - 1926</i>		
7. AGE	YEARS	MONTHS
		<i>4</i>
		<i>9</i>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work..... <i>none</i>		
(b) General nature of industry, business, or establishment in which employed (or employer).....		
(c) Name of employer.....		

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo.*
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>Alva Adams</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	12. MAIDEN NAME OF MOTHER <i>Myrtle Page</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>

14. INFORMANT *Alva Adams*
 (Address) *1437 - Blinton St*

15. FILED *15 1927* *Maule Starkeoff*
 19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 14 19 27*

17. I HEREBY CERTIFY That I attended deceased from *April 12, 1927*, to *April 13, 1927*.
 that I last saw her alive on *April 13, 1927*, and that death occurred, on the date stated above, at *12:25 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchitis acuta
10-0-0 (duration) yrs. mos. *21* ds.
 CONTRIBUTORY *Bronchopneumonia*
 (SECONDARY) *Secondary* (duration) yrs. mos. *2* ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. *at place of death*

19. DID AN OPERATION PRECEDE DEATH. *no* DATE OF.....

20. WAS THERE AN AUTOPSY? *no*
 WHAT TEST CONFIRMED DIAGNOSIS. *clinical*
 (Signed) *J. C. Creane* M. D.
Apr 14, 1927 (Address) *2504 N. 14th St*

*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 *Lexoto Mo.* DATE OF BURIAL *April 16 19 27*

20. UNDERTAKER *By Leidner and Co* ADDRESS *1417 N. Market St*

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.

