

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

Do not use this space.

31962

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.....

Registered No. **9329**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **1167 Ohio** St. **22** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **6** 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) **married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 22 - 1901**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<b>26</b>		<b>27</b>	

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) **Missouri**  
 (STATE OR COUNTRY)

10. NAME OF FATHER **Roy DeSouce**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ill**  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Isla Saunders**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Missouri**  
 (STATE OR COUNTRY)

14. INFORMANT (Address) **City Hospital**

15. FILED **OCT 20 1927** **Mar 6 Start off** REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 19 1927**

17. I HEREBY CERTIFY That I attended deceased from **Oct 17 1927** to **Oct 19 1927** that I last saw him alive on **Oct 19 1927** and that death occurred, on the date stated above, at **430 St.**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Carcinoma of cervix uteri**

CONTRIBUTORY (SECONDARY) **46**  
 (duration) yrs. mos. da.

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?  
 10/19 (Signed) **Henry B. Westerman 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 **Hannibal Missouri** DATE OF BURIAL **Oct. 22 1927**

20. UNDERTAKER **Pete Bros. 3029 Lafayette Ave.**  
 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.

Cancelled