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

Do not use this space.

34851

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9992

City St. Louis (No. ..... St. ..... Ward)

2. FULL NAME Laura Foland

(a) Residence. No. City & sanitarium St., 10 Ward. .....
(Usual place of abode) 4462 Labadie (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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: John V. Foland

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 19, 1877

7. AGE: Years 50 | Months 7 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(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) Iowa

PARENTS
10. NAME OF FATHER: Simone Eslinger
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) [illegible]
12. MAIDEN NAME OF MOTHER [illegible]
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT: Louis H Kohler
(Address) 5300 Arsenal

15. FILED NOV -8 1927, 19 Mar C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/7/27 19

17. I HEREBY CERTIFY, That I attended deceased from 10/5/27, 19, to 11/7/27, 19, that I last saw her alive on 11/7/27, 19, and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Dementia Paralytica

1 3

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (SECONDARY) 76

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Fat

(Signed) Louis H Kohler M. D

11/7/27, 19 (Address) 5300 Arsenal

*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: Valhalla
DATE OF BURIAL: 11-10-1927

20. UNDERTAKER: Provost Und Co
ADDRESS: 3710 N Grand

4462 Saladin.