

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

Do not use this space.

2710

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1003*  
(No. *1002*, No. *134 St.*)

File No.....  
Registered No. *280*  
St. .... Ward

**2. FULL NAME** *Rachel Penny*

(a) Residence. No. *1002 No 134 St.* St., *25* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *Caucas* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>abt 78</i>				

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *House work*  
(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*

**PARENTS**  
10. NAME OF FATHER *unknown*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *unknown*  
12. MAIDEN NAME OF MOTHER *unknown*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

14. INFORMANT *Mama M. Carthy*  
(Address) *1002 No 134 St.*

15. *JAN -9 1928* FILED 19 *May 6 Starrey* REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 4 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 3 1928*, to *Jan 4 1928* that I last saw him alive on *Jan 4 1928*, and that death occurred, on the date stated above, at *6:30 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Lobar Pneumonia*  
*108*  
*131*

CONTRIBUTORY (SECONDARY) *Chronic intestinal hepatitis* (duration) *2* yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....  
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *microscopic*  
(Signed) *W Moore* M. D.  
*9: 1928* (Address) *1376 Franklin*

\*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 *Chester Illinois* DATE OF BURIAL *1/9 1928*

20. UNDERTAKER *W Robt Lucas* ADDRESS *3035 Lucas*

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.

