

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

Do not use this space. 15
File No. 10691
Registered No. 2474

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis Mo. No. City Sanitarium St. _____ Ward _____

2. FULL NAME

Elda F. Stratton
(a) Residence. No. 3942 Greer Ave. St. 13 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 18 - 1890
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
37 11 17

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer) Union Electric Light & Power Co.
(c) Name of employer _____

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

10. NAME OF FATHER Wm. Stratton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Alvina D. Hellman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany.
(STATE OR COUNTRY)

14. INFORMANT Wm. Stratton
(Address) 3942 Greer Ave.

15. FILED APR -6 1923 Max B. Starckoff
19____ REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5 - 1928
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 3 - AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar
100% Pneumonia
CONTRIBUTORY (SECONDARY) Hospital

18. WHERE WAS DISEASE CONTRACTED? _____
IF NOT AT PLACE OF DEATH: _____
8/10/28 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
of St. Peter (Signed) _____ M. D.
1011 W. Corner (Address) _____

*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 St. Peters DATE OF BURIAL Mar. 7 1928

20. UNDERTAKER W. Leidner and Co. S. Market ADDRESS 1417

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.

