

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

Do not use this space.

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15745 A5

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *City Hospital #2*)

791'
1003
Registration District No.....
Primary Registration District No.....

File No.....
Registered No. *4741*
St..... Ward.....

2. FULL NAME

Nettie Yeager
(a) Residence. No. *3926 Lafayette* St., *11* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *7* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>Col.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of <i>Fred Yeager</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Feb 27, 1890</i>		
7. AGE YEARS <i>37</i>	MONTHS <i>1</i>	DAYS <i>29</i>
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Hairdresser</i> (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) *Mo.*

PARENTS	10. NAME OF FATHER <i>Wm. Young</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) <i>Mo.</i>
	12. MAIDEN NAME OF MOTHER <i>Hattie Amfenow</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) <i>Unknown</i>

14. INFORMANT *Ursula Woodard*
(Address) *City Hospital #2*

15. FILED *May 6 1928*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 26, 1928*

17. I HEREBY CERTIFY, That I attended deceased from *4/26*, 19*28*, to *4/26*, 19*28* that I last saw her alive on *4/26*, 19*28*, and that death occurred, on the date stated above, at *1945 P.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A

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

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

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

WHAT TEST CONFIRMED DIAGNOSIS *clinical*
(Signed) *A. S. Howell* M. D.
(Address) *City Hosp. #2*

*State the DISEASE CAUSING DEATH, or 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 *Washington Park* DATE OF BURIAL *5-1-28*

20. UNDERTAKER *Peoples and Co* ADDRESS *Franklin*

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City..... (No.....)

Registration District No. 991
Primary Registration District No. 1003

File No.....
Registered No. 4741
St..... Ward.....

2. FULL NAME

(a) Residence. No..... St..... 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 M 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 27 - 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 1 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of 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).....

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14.

INFORMANT (Address).....

15.

FILED May 6 1928 Max C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 26 1928

17. I HEREBY CERTIFY That I attended deceased from....., 19....., that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....
THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.
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?.....
(Signed)....., M. D.
....., 19..... (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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

information should be carefully applied. AGE should be stated EXACTLY. CIVILIANS should be stated EXACTLY. Exact statement of cause of death is very important. H in plain terms, so that it may be properly classified. ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED. PRESCRIBED BY LAW

SUPPLEMENTARY

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