

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

Do not use this space.

21824

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1008**
City.....

File No.....
Registered No. **5935**
St..... Ward)

2. FULL NAME

(a) Residence. No. **3700 Delaware** St., **19** 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. 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 **C. J. Davis**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 21 - 1892**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 9 10

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) **at home**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Germany**
(STATE OR COUNTRY) **Miss.**

10. NAME OF FATHER **Edw Collins**

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

12. MAIDEN NAME OF MOTHER **Mrs. Davis**

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

14. INFORMANT (Address) **E. J. Davis
3700 Delaware**

15. JUN -2 1928 FILED 19. **Wm E. Starkey** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6 - 1 - 1928**

17. I HEREBY CERTIFY, That I attended deceased from **4-23**, 19**28**; to **5-31**, 19**28** that I last saw **her** alive on **5-31**, 19**28** and that death occurred, on the date stated above, at **4-00** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Post operative Shock
(duration)..... yrs..... mos..... da.

CONTRIBUTORY (SECONDARY) **fractured limb following manipulation**

18. WHEN WAS POSTMORTEM EXAMINED? **5-31-28**
IF NOT AT PLACE OF DEATH? **at home**

19. DATE OF OPERATION (PREPARE DEATH) **5-31-28**

20. WAS THERE AN AUTOPSY? **no**

21. WERE TESTS CONFIRMED DIAGNOSIS? **X-Ray**
(Signed) **P. H. Harmon**, M. D.
, 19 (Address) **530 N. Union**

*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 **German Miss.** DATE OF BURIAL **6-4 1928**

20. UMBERTAKER **Harmon & Sons 625 N. Union** ADDRESS

WRITE FULLY, 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.

4064 Olive St. Lindell 00.2.7.

**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 St. Louis
Township St. Louis
City St. Louis (No. _____)

Registration District No. 991
Primary Registration District No. 1003

File No. _____
Registered No. 3935- Ward _____

2. FULL NAME

Hettie Emily (Farwe) Farwe

(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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

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 _____

Max C. Stankov
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-1-1928

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Post operative shock
fractured femur
Manipulation following

18. WHERE WAS DISEASE CONTRACTED _____
OR NOT AT PLACE OF DEATH? _____
DID OPERATIONS PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. W. Kemmer, M.D.
8/6, 1928 (Address) Dep. Coran

*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 _____

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-21824