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

Do not use this space.

16374

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 4415

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

2. FULL NAME Jane L Sturges

(a) Residence (Usual place of abode) No. Wentzvill Mo St., 12 Ward. Wentzville Mo (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: 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: William Sturges

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 27 1875

7. AGE: 53 YEARS | MONTHS: 9 | DAYS: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(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): St Charles County Mo

PARENTS

10. NAME OF FATHER: Dr Forest Lindsay
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St Charles County Mo
12. MAIDEN NAME OF MOTHER: Martha Lee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St Charles County Mo

14. INFORMANT: William H Sturges
(Address) Wentzville Mo

15. FILED APR 16 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 15 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr 13, 1929, to Apr 15, 1929 that I last saw her alive on Apr 15, 1929, and that death occurred, on the date stated above, at 7 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess, subdiaphragmatic
12.9 (Cause Unknown)
Operation for Drainage (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4/15/29
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Operation
(Signed) [signature], M. D
4/16, 1929 (Address) 3115 S Grand

*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: Bellefontaine Cem | DATE OF BURIAL: Apr 17 1929

20. UNDERTAKER: A Kron L & U Co | ADDRESS: 2707 N. Grand Blvd

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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