

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

Do not use this space.

29480

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township St. Louis Primary Registration District No. 1003  
 City St. Louis No. 1003 Hospital.....  
 St. .... Ward)

File No. ....  
 Registered No. 8659

**2. FULL NAME**

(a) Residence No. 447 N. Sarah 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. 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 George Shuck

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 2 - 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
53 7 20 .....

**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).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Cassville  
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT George E. Shuck  
 (Address) 447 N. Sarah St.

15. FILED 1929 11/24 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 22 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at 12:50 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Pyelonephritis  
9 1/2

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

18. WHERE WAS DISEASE CONTACTED Home  
 IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) J. W. Kerner M.D.

8/24, 1929 (Address) Dep. Corcoran

\*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 Catholic Burial DATE OF BURIAL 8/24 1929

20. UNDERTAKER Valhalla Cemetery ADDRESS 1710 N. Grand St.

WRITE PLAINLY, 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.

