

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

Do not use this space.

35321

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. 3967 W. Pine blvd.) St. Ward)

File No.....
Registered No. 100164
St. Ward)

2. FULL NAME Catherine de Margaret de Castro,

(a) Residence, No. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1929-9-29.

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

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

10. NAME OF FATHER Carlos de Castro,

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

12. MAIDEN NAME OF MOTHER Mary Sallos,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N. Orleans,
(STATE OR COUNTRY) La.

14. INFORMANT Mary de Castro
(Address) 3967 W. Pine blvd.

15. FILED May 2 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-8-29. 19 29

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28th, 1929, to October 8th, 1929, that I last saw her alive on October 8th, 1929 and that death occurred, on the date stated above, at 9:40 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature birth
7 mos.
154

CONTRIBUTORY (SECONDARY)

161a

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

18 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. H. Shorer, M. D.
10/13/29 (Address) 4397 Forest Park Blvd.

*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
Calvary,

DATE OF BURIAL
10/14/29.

20. UNDERTAKER

Robert Humboldt

ADDRESS
4468

Washington a

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.

