

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **ST LOUIS** (No. **ST LOUIS** **Mullanphy Hospital** St. _____ Ward)

17545

File No. _____
 Registered No. **4623**

2. FULL NAME

Henretta Getty
 (a) Residence. No. **2914 Howard** St. **20** Ward. _____
 (Usual place of abode) _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred **60** 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) **widowed**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
abt 78

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **House work**
 (b) General nature of industry, business, or establishment in which employed (or employer) **at home**
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) **Pa**

PARENTS
 10. NAME OF FATHER **John C Hoffman**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Germany**
 12. MAIDEN NAME OF MOTHER **don't know**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT **Walter Getty** (Address) **2914 Howard**

15. FILED **19** _____ REGISTRAR **Walter Getty**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 7 1930**

17. I HEREBY CERTIFY, That I attended deceased from **May 5**, 19**30**, to **May 7**, 19**30** that I last saw her alive on **May 7**, 19**30**, and that death occurred, on the date stated above, at **6:45 P** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic Myocarditis
93c
 (duration) **2** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **90B** (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

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

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) **Dr. Mander** M. D. , 19 _____ (Address) **2806 McGonard Pl**

*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 **ST Peters** DATE OF BURIAL **May 10 1930**

20. UNDERTAKER **Bullcock Kelly** ADDRESS **4416 1/2 Taylor**

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

2
10
31

