

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

Do not use this space.

24179

1. PLACE OF DEATH:

County St. Louis Registration District No. 790
 Township Central Primary Registration District No. 6023
 City Clayton Mo. (No. 141 Linden Ave) St. _____ (Ward)

2. FULL NAME

Lawea Traiger
 (a) Residence. No. 141 Linden Place 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Edward Traiger</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11</u>				
7. AGE	YEARS <u>72</u>	MONTHS <u>4</u>	DAYS <u>21</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>housewife</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u>				
(c) Name of employer				

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

PARENTS	10. NAME OF FATHER <u>N. B. Allen</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Murphysboro</u> <u>Ill.</u>
	12. MAIDEN NAME OF MOTHER <u>Sarah Colanger</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Madison Co.</u> <u>Mo.</u>	

14. INFORMANT Katherine Traiger
 (Address) 141 Linden Ave

15. FILED July 11, 1930 K. W. Sullivan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11th 1930
 17. I HEREBY CERTIFY, That I attended deceased from June 5th, 1930, to July 11th, 1930, that I last saw her alive on July 8th, 1930 and that death occurred, on the date stated above, at 2:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Myocardial Regeneration (Coronary Sclerosis)
93C
94B
97 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Arterio Sclerosis
 (duration) 9 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 8 DID AN OPERATION PRECEDE DEATH? DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) James H. McFadden M. D.
7/11, 1930 (Address) 940 Missouri Bldg.

*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 Fredericktown Mo DATE OF BURIAL July 14 1930
 20. UNDERTAKER Alexander & Sons ADDRESS 6175 Delmar

N. B.—Every CAUSE OF DEATH 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.

William O. Webster

AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION is only to be used if classified. Exact statement of OCCUPATION is only

PARMITS

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Call Mr.

1. PLACE OF DEATH

County St. Louis

Registration District No. 790

File No.

Township

Primary Registration District No. 6033

Registered No.

City Clayton (No.)

St. Ward)

2. FULL NAME

Laura Fraizer

(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. ds.

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)

July 20-1858

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day,hra. ormin.

72

4

21

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

July 11, 1930

K. W. Sullivan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 11 1930

17.

I HEREBY CERTIFY That I attended deceased from

....., 19....., 19....., 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. OCCUPATION should be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS

SUPPLEMENTARY

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