

**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. **11003**

City **St. Louis** (No. **14175**)

City **Cely Hospital**

File No. **40840**

Registered No. **11483**

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. **21167 Odessa** St., **26** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **20** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 6 1930*

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

17. I HEREBY CERTIFY, That I attended deceased from *Nov 18*, 19*30*, to *Dec 6*, 19*30*, that I last saw h. *9* alive on *Dec 6*, 19*30*, and that death occurred, on the date stated above, at *12:30 P. M.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 29 1881*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE
YEARS *49* MONTHS *4* DAYS *7*
If LESS than 1 day, hrs. or min.

Chronic Myocarditis
936
(duration) yrs. mos. ds.

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.

CONTRIBUTORY (SECONDARY) *None*
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

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

10. NAME OF FATHER *Mr James*

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____
20. WAS THERE AN AUTOPSY? *No*

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Joseph T. Reilly* M. D.
12/7 1930 (Address) *Cely Hospital*

12. MAIDEN NAME OF MOTHER *Unknown*

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

*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.

14. INFORMANT (Address) *City Hospital*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Portageville Mo* **DATE OF BURIAL** *12-8 1930*

15. FILED *10-8 1930* *May C. Stankoff* REGISTRAR

20. UNDERTAKER *Arthur J. Donnelly* **ADDRESS** *2039 Wash St*

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.

Watson