

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

Do not use this space.

22857

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis Mo.* (No. *City Hosp. #2*)

File No.
Registered No. **6285**
St. Ward)

2. FULL NAME

Alice Ward (*Alice Ward*)
(a) Residence. No. *3403 Lawton* St., Ward. *21*
(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 <i>Female</i>	4. COLOR OR RACE <i>Cauc</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>1890</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>12-8-1890</i>		
7. AGE	YEARS <i>40</i>	MONTHS <i>5</i>
	DAY <i>23</i>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Laundress</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>2 2 3</i> (c) Name of employer		

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

PARENTS

10. NAME OF FATHER <i>Unknown</i>
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <i>Iowa</i> (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER <i>Unknown</i>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <i>Iowa</i> (STATE OR COUNTRY)

14. INFORMANT..... *A Glendale Health City Hospital #2*
(Address)

15. FILED..... *1931* *W. E. Starker*
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-7-1931*

17. I HEREBY CERTIFY, That I attended deceased from..... *5/26*, 19*31*, to *6/1*, 19*31*
that I last saw h..... alive on..... *6/1*, 19*31* and that death occurred, on the date stated above, at..... *10:30 P.m.*

108 THE CAUSE OF DEATH* WAS AS FOLLOWS:
1148 Lung Abscess (non-tubercular)

CONTRIBUTORY (SECONDARY) *Lobar Pneumonia* (duration) yrs. *1* mos. *7* ds.
(duration) yrs. mos. *14* ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH..... *Home*
DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY? *Yes*
WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*
(Signed) *W. E. Starker*..... M. D.
6/3 . 19*31* (Address) *City Hosp #2*

*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 <i>Greenwood Cem.</i>	DATE OF BURIAL <i>6-5-1931</i>
20. UNDERTAKER <i>Amer. Funeral Home</i>	ADDRESS <i>3444 Pine</i>

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.

