

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

Do not use this space.

**26601**

**1. PLACE OF DEATH**

County.....

Registration District No.....

**791  
1003**

Township.....

Primary Registration District No.....

City *St. Louis Mo* (No. *Christian Hosp*)

File No.....  
Registered No. **7755**  
St. .... Ward)

**2. FULL NAME**

*Virginia Mae Miner*  
(a) Residence, No. *4544 Lexington Ave* St. *10* 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 6 - 1931*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
		<i>1</i>	<i>6</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *none*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

13. NAME *Thomas E. Miner*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

15. MAIDEN NAME *Viолetta Steiner*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ills*

17. INFORMANT (ADDRESS) *Thomas E. Miner  
4544 Lexington Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Valhalla* DATE *July 14 1931*

19. UNDERTAKER (ADDRESS) *W. J. Leidner, Third Co  
1417 N. Market St.*

20. FILED *UL 13 1931* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 12 1931*

22. I HEREBY CERTIFY That I attended deceased from *June 29 1931* to *July 12 1931*  
last saw h. or alive on *July 12 1931*. Death is said to have occurred on the day stated above, at *9 P.M.*  
The principal cause of death and related causes of importance were as follows:

*Acidosis  
Pyloric spasm*  
*1198  
1378*  
Other contributory causes of importance:  
*Wagener's non-specific* *6-28-31*

Date of onset <i>7-11-31 6-28-31</i>
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Name of operation..... Date of.....  
What test confirmed diagnosis? *ys* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify.....  
(Signed) *W. J. Leidner*  
(Address) *718 Deane St. Med Bldg  
3770 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.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis

Registration District No. 791

Township St. Louis

Primary Registration District No. 1003

City St. Louis (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. 7723-

**2. FULL NAME**

Virginia Mae Miner

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 12, 1931

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Other contributory causes of importance: 9-30-31

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

asthonia  
Diabetic Spasms  
Non Diabetic Audios  
Information given over Phone by  
Dr. R. Robinson, Div. of P. S.  
Vaginitis non Specific

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS)

20. FILED SEP 30 1931

Just C Parker  
Registrar

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state SE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

