

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

Do not use this space.

42874

1. PLACE OF DEATH

County..... Registration District No. *781 1072*
Township..... Primary Registration District No. *2638 Keokuk*
City..... *St. Louis*

File No.....
Registered No. **12800**
St. Ward)

2. FULL NAME

(a) Residence, No. *2638 Keokuk* St., *24* 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? *20* 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>widow</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>About 1871</i>		
7. AGE YEARS	MONTHS	DAYS
<i>About 60</i>	<i>Unknown</i>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housewife</i>	
	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	

MEDICAL CERTIFICATE OF DEATH

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21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec. 28*, 19*31*

22. I HEREBY CERTIFY, That I attended deceased from *12-26*, 19*31*, to *12-29*, 19*31*

I last saw him alive on *12-29*, 19*31*. Death is said to have occurred on the date stated above, at *9:30 AM*

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

Intestinal Hemorrhage following fall on bare steps

at Residence

Accident

1861

Other contributory causes of importance: *Bleeding from fracture of clavicle following fall on bare steps*

Date of onset *12-26*

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<i>Austria</i>
	13. NAME	<i>Unknown</i>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<i>Austria</i>
	15. MAIDEN NAME	<i>Unknown</i>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<i>Austria</i>
	17. INFORMANT (ADDRESS)	<i>Dr. Gladish 2638 Keokuk St.</i>
	18. BURIAL, CREMATION, OR REMOVAL PLACE	<i>New Yorker Dec. 30 1931</i>
	19. UNDERTAKER (ADDRESS)	<i>Thos. Suetis 2906 Gravois Ave</i>
	20. FILED	<i>DEC 28 1931</i>

Name of operation *none* Date of

What test confirmed diagnosis? *C. 4147* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *Accident* Date of injury *12-26*, 19*31*
Where did injury occur? *St. Louis Mo*
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *at home*
Nature of injury *Fall on steps*

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify

(Signed) *Edwin C. Boyd* M. D.
(Address) *3772 Harrison*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Registrar

