

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

Do not use this space.

1. PLACE OF DEATH

County Jackson

Registration District No. 10

Township W. 1st

Primary Registration District No. 10

City St. Louis

Ward 10

File No. 29300

Registered No. 88717

St. 10 Ward

2. FULL NAME

(a) Residence, No. 5111 Marine Ward.

(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 Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 13 - 1934

7. AGE YEARS 2 MONTHS 8 DAYS 26 If LESS than 1 day, hrs. or min.

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

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

13. NAME Alonzo Chapman

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

15. MAIDEN NAME Bertha Woodruff

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

17. INFORMANT (ADDRESS) Alonzo Chapman

18. BURIAL, CREMATION, OR REMOVAL Green Lawn DATE Aug 9 1937

19. UNDERTAKER (ADDRESS) 14135 East 13th

20. FILED Aug 10 1937 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 9 1937

22. I HEREBY CERTIFY THAT the deceased died from Bronchopneumonia

I saw him alive on 3-25-37 19 Death is said to have occurred on the date stated above, at 11:00 a.m.

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

Other contributory causes of importance:

Name of operation Autopsy Date of operation Aug 9 1937

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in about the following: Accident, suicide, or homicide? None Date of injury Aug 9 1937

Where did injury occur Home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? None

If so, specify None

(Signed) [Signature], M. D.

(Address) [Signature]

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.

Kansas City

WASHINGTON

3717

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Gladys Chapron*
Who died at _____ on *Aug 9 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *W* Single, ~~married~~, ~~widowed~~ or ~~divorced~~: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) *Broncho pneumonia*
Birthplace of father (State or country) _____
Birthplace of mother (State or country) *No primary for sub pneumonia*
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician *Dr. C. G. Reitch Supply Coroner*
Address of physician *439 Greenwood Avenue*
Signature of registrar *M. M. Edome* Date filed *9/10/34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,
E. T. McGaugh M.D.
Special Agent. *S.E.*

Reg. Dist. No. _____
Primary Reg. Dist. No. _____