

OCT 17 1934

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

Do not use this space.

33062

1. PLACE OF DEATH

County

Township

(City)

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

St.

Ward

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

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.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

7. AGE

YEARS

MONTHS

DAYS

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)

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. UNDERTAKER (ADDRESS)

20. FILED

9-29-34

1934

Mo

St. Louis

City

Ward

17th

St. Louis

City

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from

I last saw her alive on 9-27-34 Death is said

to have occurred on the date stated above, at 11:30 a.m.

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

This Colitis

Other contributory causes of importance:

myocarditis acute

Name of operation Laparotomy Date of 9-22-34

What test confirmed diagnosis? W. H. R. 1130 Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no Date of injury no

Where did injury occur? no (Specify city or town, county, and State)

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

Manner of injury no

Nature of injury no

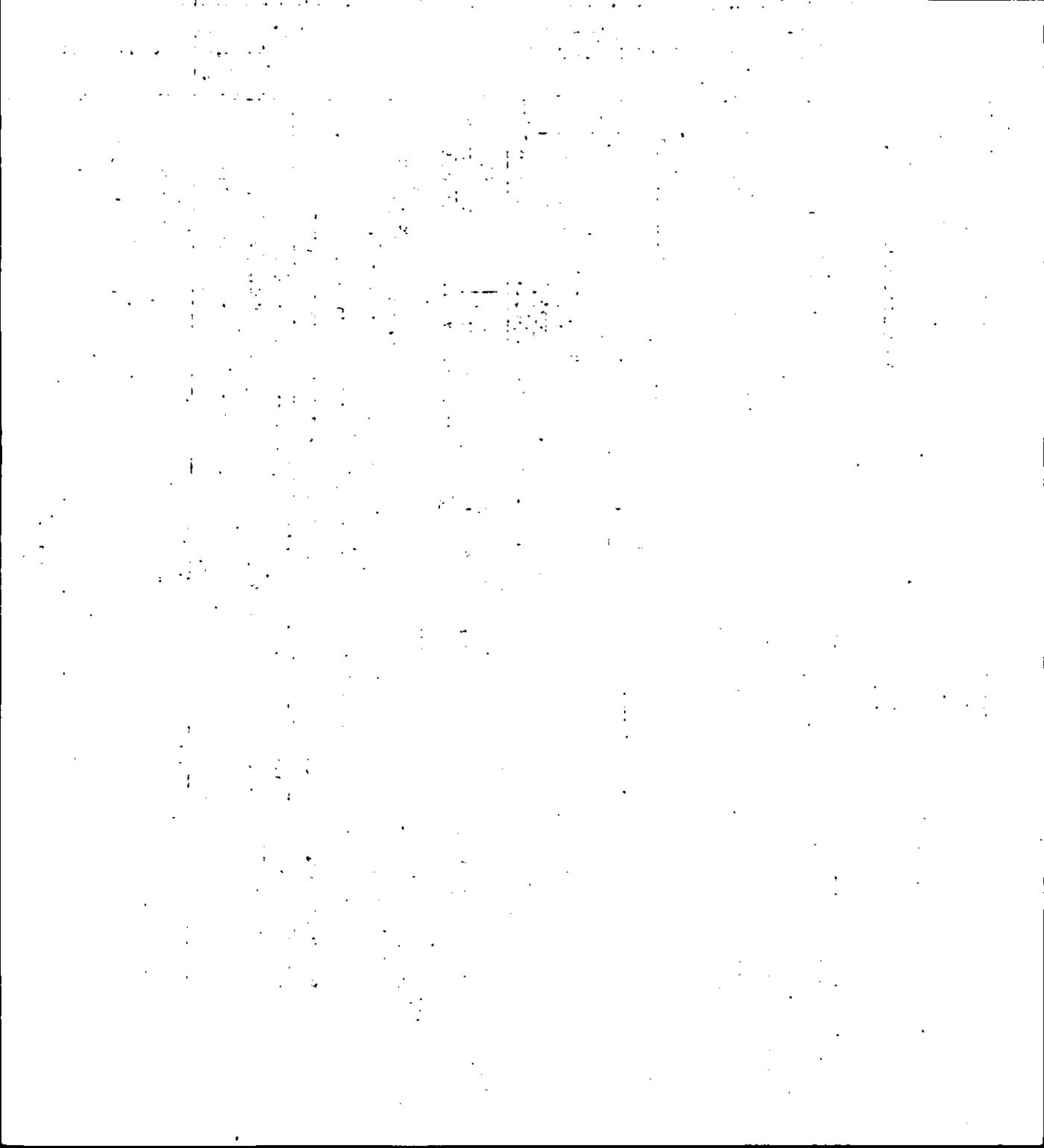
24. Was disease or injury in any way related to occupation of deceased?

If so, specify no

(Signed) Clyde A. Kaehler M. D.

(Address) 1828 21st St. St. Louis

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

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: Cara Lee Wilson

Who died at Whitely Park Hoop on Sept 27 - 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 B Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 48 Months 2 Days 9

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: Ills. Calicut Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Operation for Fibroid tumor, Cystic Ovaritis, Cha Appendicitis

Other contributory causes of importance: myocardial acute Fibroid tumor, Cystic Ovaritis, Cha Appendicitis

Name of operation: Tam hysterectomy Date of not performed

What test confirmed diagnosis? clinical Was there an autopsy? yes

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 E. A. Walker

Address of physician 1820 Vine St

Signature of Registrar M. M. Brown Date filed 9/29/34

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. McLaughlin
State Registrar

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

Special Agent.

29053-5