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

Do not use this space.

28590

File No.

Registered No. 8496

1. PLACE OF DEATH

791

County ..... Registration District No. 10452

Township ..... / Primary Registration District No. /

City St Louis (No. City Hospital St. Ward)

2. FULL NAME Mrs Laura Earls

(a) Residence. No. 1718 Franklin St. 25 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

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

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

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
ab. 58			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT E Kinsey

(Address) City Hospital

15. FILED AUG 27 1930 Earl C Kinsey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 26, 1930, that I last saw h. alive on Aug 24 1930 and that death occurred, on the date stated above, at 11.30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cellulitis of Left Leg (Cause unknown)

Chronic Myocarditis

Chronic Nephritis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Carl Hoffstetter, M. D

Aug 26, 1930 (Address) City Hospital

*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 St. James Mo. DATE OF BURIAL 8-28 1930

20. UNDERTAKER J. P. Murrell's Sons ADDRESS 1407 Market

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.

Carbs