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.

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

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

1 PLACE OF DEATH

County St. Louis

Township Meramec
or
Village Glencoe
or
City ..... (NO. ..... St. ..... Ward)

Registration District No. 785 File No. 23248

Primary Registration District No. 6032 Registered No. 82

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alice Dorsey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Negro

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan (Month) 12 (Day), 1884 (Year)

7 AGE 35 yrs. 5 mos. If LESS than 1 day, ... hrs. ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Mother
(b) General nature of industry business, or establishment in which employed (or employer) at Home

9 BIRTHPLACE (City or town, State or foreign country) Meramec township, St Louis Co.

PARENTS

10 NAME OF FATHER Philander Hawkins

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis Co. Mo.

12 MAIDEN NAME OF MOTHER Amanda (nee) Hawkins

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) St. Louis Co. Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Dorsey

(Address) Glencoe R.F.D 17 Mo.

15 Filed 7-18, 1919 C A Dunnavant Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 6 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 8, 1919, to July 6, 1919 that I last saw her alive on July 6, 1919 and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A 28

Co. (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Wilson Dean M. D.

7/7, 1919 (Address) Cultour. R.F.D

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Mount Pleasant Cmtry

DATE OF BURIAL July 8, 1919

20 UNDERTAKER Wm Schrader

ADDRESS Ballwin Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Medical Association]

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St., ... Ward)

[If dea
hospital
give its
of street

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE .....yrs.....mos.....ds. | If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day)

17 I HEREBY CERTIFY, that I attended dec
....., 191....., to.....
that I last saw h.....alive on.....
and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration).....yrs.....mo

CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mo

(Signed) .....
....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violen
(1) Means of Injury; and (2) whether Accidental, Suicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, or Recent Residents)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BU

20 UNDERTAKER | ADDRESS