LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

37777

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11203

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Gussie Cook

(a) Residence. No. 2306 Eugenia St., 4 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 24, 1889

7. AGE: Years 33 | Months 11 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laundress 134B 54B 141
(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) Tenn.

PARENTS

10. NAME OF FATHER Charlie James
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Mattie Wells
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Tenn.

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED DEC 11 1923 19 Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 7, 1923

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1923 to Dec. 7, 1923 that I last saw her alive on Dec. 7, 1923, and that death occurred, on the date stated above, at 7:40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: General Peritonitis following operation for uterine fibroid and bilateral tuboovarian abscesses

(duration) ..... yrs. ..... mos. 5 ds.

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

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Nov. 28-23

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [illegible], M. D

, 19 (Address) City Hospital No. 2,

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Fiter-Dickson Cem. DATE OF BURIAL: Dec 11, 23

20. UNDERTAKER: A. L. Beal ADDRESS: 2926 St. Louis Ave

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...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)

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. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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