LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

5613

~~3243~~

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

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 1194

City St. Louis, Mo (No. 1128 A High St. ..... St. ..... Ward)

2. FULL NAME Lorane Douglas

(a) Residence. No. 1128 A High St., 5 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	Colored	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-19-24

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	5	12	

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Pete Douglas

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

12. MAIDEN NAME OF MOTHER Mabel Blackwell

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

14. INFORMANT Pete Douglas
(Address) 1128 A High St.

15. FILED ..... 19.. Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 1 19 25

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 8:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Broncho Pneumonia
1070
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) W. M. A.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1004
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) R. S. Vitt, M. D
2/2, 1925 (Address) Coroner

*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
Washington Park	2-2 1925
20. UNDERTAKER	**ADDRESS**
W. S. Wade Und. Co.	4202 Finney Av.

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

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 .....

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

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

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

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.....,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.)

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