LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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.

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

31585

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 9812

City St Louis Mo (No. City Hosp #2 ..... St. ..... Ward)

2. FULL NAME Lillie Fleming

(a) Residence. No. 2830 Leonard St., 7 Ward. (Usual place of abode) ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 2/8/1884

7. AGE: Years 41 Months 8 Days 11 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) Maid
(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER: Andrew Kemp
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Miss
12. MAIDEN NAME OF MOTHER: Matilda Rabow
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Miss

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

15. FILED OCT 22 1925 19 Mar C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10/19 1925

17. I HEREBY CERTIFY, That I attended deceased from 10/13, 1925, to 10/19, 1925 that I last saw her alive on 10/19, 1925, and that death occurred, on the date stated above, at 245 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY): Hysterectomy for Non Malignant Fibroid uterus (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 39

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 10/16/25

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L. Lomsany, M. D

10/20, 1925 (Address) City Hosp #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: Artesia Miss. DATE OF BURIAL: Oct 23 1925

20. UNDERTAKER: R. M. C. Green ADDRESS: 3517 Laclede ave

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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.....

(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)

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

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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