

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

Do not use this space.

2738

**1. PLACE OF DEATH**

County..... Registration District No.....  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis** (No. **3707**) **Chautau ave** St. **310** (Ward)

**2. FULL NAME**

**Nellie Grant**  
 (a) Residence, No. **3707 Chautau ave** St. **10** 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 <b>Female</b>	4. COLOR OR RACE <b>Col</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Widowed</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>Nov. 9, 1875</b>		
7. AGE YEARS <b>51</b>	MONTHS <b>1</b>	DAYS <b>28</b>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <b>Housewife</b> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <b>St. Louis</b> (STATE OR COUNTRY) <b>Mo</b>		
PARENTS	10. NAME OF FATHER <b>Andrew White</b>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <b>Unknown</b> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <b>Nellie Watkins</b>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <b>Mo</b> (STATE OR COUNTRY)	

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 7** 19**27**  
 17. I HEREBY CERTIFY, That I attended deceased from **1910** to **1927** that I last saw **h. w.** alive on **Jan 5**, 19**27**, and that death occurred, on the date stated above, at **St. Louis**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Syphilis**

CONTRIBUTORY (SECONDARY) **38** (duration) **14** yrs. mos. ds.

18. WHERE AS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **M. M. Conell**, M. D.

, 19 (Address) **1141 Pine St**

\*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.

14. INFORMANT **Jessie Grant**  
 (Address) **2916 Morgan St**  
 15. FILED **JAN 10 1927** **Man Starkoff**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood Cem** DATE OF BURIAL **1-11-1927**  
 20. UNDERTAKER **G. Scott, 3015 Lawton, ave** 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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

