

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

St. Louis Mo. (No. 1719 Glasgow)

1003

File No.....

Registered No.....

St. Ward

2. FULL NAME

Louisa Gaw

(a) Residence. No. *1719 Glasgow* St., *20* Ward.

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.

(If nonresident give city or town and State)

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

widowed

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

10-21-1858

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

68

2

17

8. OCCUPATION OF DECEASED

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

House Keeper

(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)

Fayette Mo.

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Fayette Mo.

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Fayette Mo.

14.

INFORMANT

(Address)

Sally Anderson

1719 Glasgow Ave

15.

FILED

JAN 12 1927

Max B. Yarocoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan - 8 - 1927

17.

I HEREBY CERTIFY That I attended deceased from *12-31-1926* to *1-8-1927*.

that I last saw him alive on *1-8-1927*, and that death occurred, on the date stated above, at *8:30 p. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of uterus

CONTRIBUTORY (SECONDARY)

46

(duration) yrs. mos. ds.

(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? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Bones Hospital*

(Signed)

Eustine D. Johnson, M. D.

, 19

(Address) *3201 Franklin Ave*

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Frieden Cemetery

Jan 12 1927

20. UNDERTAKER

A. L. B. Bevi

ADDRESS

4726 Lucasan

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.

RECORD

