

**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. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo**

(No. **City Hosp. No.**)

File No. **2981**

Registered No. **571**

St.

Ward)

2. FULL NAME

Sally Terry

(a) Residence. No. **240 Elliot** St., **21** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **26** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 or (OR) WIFE OF

Albert Terry

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

April 25, 1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

42 8 20

8. OCCUPATION OF DECEASED

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

(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)

Ky.

10. NAME OF FATHER

not known

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

not known

12. MAIDEN NAME OF MOTHER

Sally Caldwell

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

not known

14.

INFORMANT (Address) **Max F. Woodard City Hospital #2**

15.

FILED **17 1927** **Max Starceff** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan. 15 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 12**, 19**27** to **Jan 15**, 19**27**, that I last saw h. **alive** on **Jan 15**, 19**27** and that death occurred, on the date stated above, at **9:50 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
AAA
AAA (duration) yrs. **2** mos. **7** da.
CONTRIBUTORY **Chronic Valvular Heart Disease**
(SECONDARY) **Indefinite** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

○ DID AN OPERATION PRECEDE DEATH? **no** DATE OF **no**
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & laboratory**
(Signed) **J. W. ...** M. D.
City, Mo.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Washington Park

DATE OF BURIAL

Jan 18, 1927

20. UNDERTAKER

W. C. Gordon

ADDRESS

2649 Morgan

WRITE PLAINLY, WITH UNFADING INK. 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.

