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

Do not use this space.

3205

1. PLACE OF DEATH

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

Township..... Primary Registration District No. 1003 Registered No. 804

City St. Louis (No. 5701 Clemens Av. St. ..... Ward)

2. FULL NAME Cassie Mullins

(a) Residence. No. 5701 Clemens Av. 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*)
Male	Col.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/8/1899

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	0	10	

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

9. BIRTHPLACE (CITY OR TOWN) Stuttgart
(STATE OR COUNTRY) Ark.

PARENTS

10. NAME OF FATHER Unknown

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 H. W. Fash
(Address) Coroner's Office

15. FILED JAN 24 1927 Max C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/18 1927

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 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Stab Wound of Heart (Knife).
Homicide
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 198
(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? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. W. Fash M.D.

1/21, 1927 (Address) Deputy 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Stuttgart, Ark. DATE OF BURIAL 1-25 1927

20. UNDERTAKER People's Und. Co. ADDRESS 3100 Franklin

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.