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

Do not use this space.

6633

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 1858

City ST. LOUIS MO. (No. ST. JOHNS. HOSPITAL. St. ..... Ward)

2. FULL NAME LENA JAMISON.

(a) Residence. No. 4318 LEE. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
FEMALE.	WHITE.	MARRIED.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/18/66.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60	11	3	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) SELF

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) MISSOURI.

PARENTS

10. NAME OF FATHER ~~[illegible]~~ WALPERS.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) NOT KNOWN.

12. MAIDEN NAME OF MOTHER " " " "

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

14. INFORMANT Lowell Jamison
(Address) 4318 Lee Ave.

15. FILED FEB 24 1927 19 Max C Starkloff REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/21/ 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-11-27 ....., 19....., to 2-21, 1927 that I last saw her alive on 2-21-27, 19....., and that death occurred, on the date stated above, at 4:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Nephritis

92C

130

90B

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chr. Myocarditis (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? at Home

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Urine analysis

(Signed) W. R. McIntyre, M. D

, 19 (Address) 2900 N. Euclid ave

*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 VALHALLA.

DATE OF BURIAL 2/24/ 1927

20. UNDERTAKER Provost Bud Co

ADDRESS 3710 N. Grand

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.