

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

Do not use this space.

10314

1. PLACE OF DEATH

County St. Louis Registration District No. 791
Township St. Louis Primary Registration District No. 1008
City St. Marklet (No. 4239)

File No. _____
Registered No. 2906
St. _____ Ward _____

2. FULL NAME

Katie Gibbs
(a) Residence No. 4239 N. Market St. Ward 11
(Usual place of abode)

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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 18 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
67 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employee) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Not known
(STATE OR COUNTRY)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

14. INFORMANT Gillie Douglas
(Address) 4232 St. Francis

15. FILED 25 1927 Max G. Starckoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-20 1927

17. I HEREBY CERTIFY, That I attended deceased from 3-18, 1927, to 3-20-27, 1927, that I last saw her alive on 3-20-27 at 12:30 PM, and that death occurred, on the date stated above, at 11:30 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
Apoplexy
(duration) yrs. mos. ds. 3

CONTRIBUTORY (SECONDARY) HTA
(duration) yrs. mos. ds. —

18. WHERE WAS DISEASE CONTRACTED St. Louis
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examination
(Signed) W. H. Groenewey, M. D.

3-26-27 (Address) 1506 St. Louis

*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 Greenwood Cem. DATE OF BURIAL 3/25 1927

20. UNDERTAKER Manuel Galt Co. ADDRESS 176 59 1/2 Times

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.

