

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

Do not use this space.

10487

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (City Hospital #2) St. **Ward**

File No.....
 Registered No. **3097**

2. FULL NAME

(a) Residence. No. **1813 1/2 S. Fallon St.** (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **1** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **11-17-1883**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	43	4	11	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

Amos Redford

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Rachel [unclear]

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

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

15.

FILED **31** 1927 **Mar 6 Starkoff**
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 28 1927**

17. I HEREBY CERTIFY, That I attended deceased from **March 5** 1927, to **March 28** 1927, that I last saw him alive on **March 28**, 1927, and that death occurred, on the date stated above, at **6:45 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of uterus

CONTRIBUTORY (SECONDARY) **46**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

20. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Cytological**

(Signed) **J. J. Thomas**, M. D.

*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

Brook Washington

DATE OF BURIAL

4/3 1927

20. UNDERTAKER

R. M. C. Green

ADDRESS

3517 Laskade

aoe

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.

