

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

Do not use this space.

16380

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis, Mo.* (No. *City Hosp. No. 2*)

File No.

Registered No. **4265**

St. Ward)

2. FULL NAME

(a) Residence. No. **3118 Lowell** St., **21** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **1 1/2** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

negro

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

Single

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

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

Jan. 1, 1946

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

1

4

3

8. OCCUPATION OF DECEASED

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

ml.

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

S S

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Clemie Bell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Rosa Sloan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14.

INFORMANT

(Address)

*Anna F. Woodard
City Hospital # 2*

15.

FILED

NOV - 5 1947

19...

*Max B. Starckoff
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 14* 19 *47*

17. I HEREBY CERTIFY, That I attended deceased from *May 5*, 19 *47* **to** *May 14*, 19 *47* **that I last saw him/her alive on** *May 13*, 19 *47*, **and that death occurred, on the date stated above, at** *16 15/2 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Tuberculous meningitis
of the Meninges
3 HR (duration) yrs. mos. 15 da.*

CONTRIBUTORY (SECONDARY)

3 2 0 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

0 DID AN OPERATION PRECEDE DEATH? *no*, DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory*

(Signed) *J. W. ... M. D.*

, 19 (Address) *City Hosp. No. 2*

*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

DATE OF BURIAL

Washington Park

May 6 1947

20. UNDERTAKER

ADDRESS

J. E. Thomas

3111 Lowell

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.

